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Culture and healthcare toward Vietnamese adults and elderly of Greater Springfield, Massachusetts.

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CULTURE AND HEALTHCARE TOWARD VIETNAMESE ADULTS AND ELDERLY OF GREATER SPRINGFIELD, MASSACHUSETTS

A Dissertation Presented

by

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DEDICATION

For my loving wife, Son, and my three wonderful children: Trong, Hanh, and MyDzung. You have always been my number one supporters and bring richness and meaning to my life.

And, for my deceased mother. Although she was illiterate, she devoted her entire life to her three sons, and encouraged them to reach for an education. Her spirit will remains always within my soul

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ABSTRACT

CULTURE AND HEALTH CARE TOWARD VIETNAMESE ADULTS AND ELDERLY OF THE GREATER SPRINGFIELD, MASSACHUSETTS

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The relationship of culture and healthcare plays an important role in the success of health care access for everyone. In recent decades, the United States has opened its door to welcome not only refugees and immigrants from Europe, but also from other countries all over the world. Coming to the United States, these ethnic groups must overcome many problems to adjust to the American healthcare system. Meanwhile, American health providers not only misunderstand their refugees and immigrant clients' culture, but also want them to conform to the requirement of purely biomedical treatment. The result is that access to healthcare for immigrant groups in the United States is likely to be difficult because of significant cultural differences between the clients and healthcare provider.

This research used in depth-interviews, participant observations, and a case study to explore the interaction between culture and healthcare for Vietnamese refugee and immigrant adults and elderly living in the Greater Springfield, Massachusetts area; the

level of their involvement in the American healthcare and in traditional healthcare; the extent of integration of American healthcare and traditional healthcare; the obstacles they face in accessing and using American healthcare; and the importance of health education in successful healthcare access.

Theories of acculturation, such as Models of Acculturation (Padilla, 1980) and Health Care System Model (Kleinman, 1978a) were used to process the study data to determine the extent of the influence of culture on the effectiveness of healthcare. Finally, based on data analysis, I explain how Vietnamese refugee and immigrant adults and elderly acculturate to the American healthcare system, and make recommendations for improving healthcare for them, as well as for other ethnic groups throughout America.

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CHAPTER I

INTRODUCTION

Statement of the Problem

In recent decades, the relationship between culture and healthcare has been a controversial issue of great concern, because of the crucial healthcare needs of increasing numbers of minority groups in the United States. Obviously, culture and healthcare are deeply intertwined. Different cultures have different health beliefs, health behaviors, and health practices. Culture has been defined as "the integrated pattern of human knowledge, belief, and behavior that depends upon man's capacity for learning and transmitting knowledge to succeeding generations...." (Merriam-Webster's Collegiate Dictionary, p. 282). It penetrates deep within the human being and is a part of human life. In the course of their life, people of one culture may have a very hard time for adjusting to a new society, in which they were not born and raised.

The United States is a country of many different nationalities. Since its beginning, the United States has received millions of refugees and immigrants from Europe because of various political, economic, and religious upheavals. In 1965, Congress passed the Amended Immigration Naturalization Act to open America's doors not only to Europeans, but also to all nationalities, and the numbers of refugees and immigrants have increased ever since. Most of these recent refugees and immigrants came from the developing countries, especially Latin America and Asia. The United States now has more cultural and ethnic groups than ever, which has led the government to address their needs for healthcare, employment, and education.

Among these minority groups, the United States has welcomed millions of Vietnamese refugees and immigrants since the end of the Vietnam War in 1975. They came to America in reaction to discrimination by the Communists. They were resettled all over the country, but particularly in California and Texas. Massachusetts has received thousands of Vietnamese refugees and immigrants who are concentrated mostly in Boston, Worcester, and Springfield. Like other ethnic groups, Vietnamese refugees and immigrants cannot easily adjust to American society because their own culture is so different from that of the American population. Many Vietnamese feel homesick, stressed, or have mental health problems, and prefer to live in their own communities, separated from outsiders. Many Vietnamese have problems with the American healthcare system, because their health beliefs, behaviors, and practices are fundamentally different from those of American people.

Contrary to the Western belief that disease is caused by bacteria or viruses causing damage to parts of the body, Vietnamese medicine perceives that disease is due to an imbalance between the "Cold" and "Hot," or the "Wind" (Hoang & Erickson, 1985), which exist in the universe and are ready to penetrate anybody not protected. The traditional way to treat health problems is therefore to balance this "Hot" and "Cold."

In addition to "Hot" and "Cold" theory, most Vietnamese refugees and immigrants are Buddhists, Confucians, or Taoists. These religions blended together to form the "three teachings" philosophy that influences Vietnamese in healthcare utilization. The doctrine of Buddhism, which is very different from Western religions, encourages everyone to embrace and suffer the misfortune or illness, and considers disease a result of desire or wrongdoing. Buddhists need to endure disease to purify their

souls. Confucianism, on the other hand, stimulates people to follow the hierarchy in society. Harmony in family and society is a factor for happiness and healthiness. To be healthy, one should fulfill his or her obligations toward family and society. Taoism encourages followers to avoid being involved in society, but blended into nature instead. Nature will calm the soul and make people healthy.

In accessing healthcare, instead of using one health system as most Americans do, Vietnamese refugees and immigrants participate in three different "system": Chinese medicine, the Vietnamese traditional medicine, and the Western medical system. With minor health problems such as coughing, fever, or headache, Vietnamese refugees and immigrants will go to the healer and use traditional health practices; if the problem becomes serious they will then go to the Western doctor.

Like others in minority groups, many Vietnamese are low-income, and have little or no health insurance coverage. They cannot get jobs with benefit packages that include health insurance due to a lack of job skills. Their uninsured rate is very high: 26.7%, compared to 13.9% for the native population (Camatora & Edward, 2000). Most of them are foreign-born, and the need to use the English language is another barrier when they attempt to access Western healthcare.

The problem becomes complicated when many American healthcare providers, being proud of their ability to deliver "quality" healthcare, perceive biomedicine, or medicine based on physiology and biology as the best way to resolve all health problems. They are satisfied with their own procedures and have no regard for the healthcare practices of many countries over the world, even though these systems can be effective and even heal what Western medicine cannot. American healthcare providers

not only refuse to recognize healthcare practices different from their own; more than anything, they want their ethnic patients to conform their health beliefs and behaviors to a biomedical regimen (Dresser & Oths, 1997). Additionally, the American government has an inconsistent and poorly planned healthcare policy for Vietnamese as well as other new ethnic arrivals. It only responds to crisis, rather than making carefully reasoned plans (Mundoon, 1990) in which health education would have an important role for both American healthcare providers and their Vietnamese patients.

With such cultural differences, Vietnamese refugees and immigrants cannot help getting confused by and irritated with the American healthcare system. How quickly they adjust or assimilate into the American system is dependent both on the strength of their attachment to their traditional culture and the environment they live in.

Purpose of the Study

This study aims to explore the interaction between cultural influences and healthcare for the Vietnamese refugee and immigrant adults and elderly of Greater Springfield. For many healthcare needs, they are involved in the American healthcare system; at the same time, they also practice traditional healthcare. The research examines the level of their involvement in the American healthcare system versus traditional healthcare, and the obstacles they face in using the American system. This study aims to discover how Western and traditional healthcare can be interwoven to promote healthcare, the importance of health education, and which policies and strategies are necessary to improve healthcare for the Vietnamese refugees and immigrants of Greater Springfield.

The Researcher

I have many advantages in my research on healthcare for Vietnamese refugee and immigrant adults and elderly of Greater Springfield. First of all, I am a Vietnamese refugee and a permanent resident of Springfield. I have lived in my community since I first came to the United States in 1992. At that time, the Vietnamese population was on the way to becoming its own community. Ever since I came here, I have been exposed to the healthcare practices of my fellow refugees and immigrants. As an outreach healthcare worker for more than ten years, I have worked with Vietnamese, Hmong, and Cambodian people in the communicable disease prevention program. I have had many opportunities to interact with patients, through educating them, following up with them, and monitoring their treatments. As a result, I understand the conflicts they face and how they deal with them. I am also a member of many organizations in this community. I have opportunities to interact with community leaders, the elderly, and outside organizations such as the Springfield Health and Human Services Department. I also have the advantage of being a part of the Massachusetts Refugee and Immigrant Health Program, which allows me to work directly with the community.

Significance of the Study

This study contributes to the existing research on the influence of culture on healthcare for minority groups in America. Although this research focuses on the Vietnamese refugee and immigrant population, there is an urgent need for the American healthcare system to have an appropriate policy regarding all minority groups, since the minority population has been increasing dramatically in recent decades.

To provide healthcare for all Americans, the government, both state and federal, has initiated numerous new health programs for minority groups. To make these programs effective in Massachusetts, the Refugee and Immigrant Health Program, the Department of Public Health, and the Western Massachusetts Mental Health Task Force need more information on Vietnamese culture and tradition, to improve and strengthen the health of new arrivals.

This research is useful and necessary for community health planning. In Springfield, the Southwest Community Health Center, Mercy Hospital, and Baystate Medical Center all work directly with Vietnamese refugees and immigrants. These institutions need research of this kind to enable more appropriate planning and provide more effective health services to that population. This research will also be helpful to health educators who are working with other minority groups in the United States. Healthcare access is not enough without health education. To broker a successful healthcare alliance, health education must be addressed to both healthcare providers and their clients in an appropriate cultural setting.

Research Questions

To study how culture influences healthcare for the Vietnamese refugee and immigrant adults and elderly of Greater Springfield, four major questions will be examined:

1. What is the relative level of involvement of Vietnamese adults and elderly with the American healthcare system and their traditional healthcare?

(a) Why do they both access Western healthcare and practice their traditional methods?

(b) How do they feel when using Western healthcare?

(c) How do they feel when using traditional health care?

2. What healthcare access problems have the Vietnamese adults and elderly encountered?

(a) How do economics, education, and employment influence the healthcare access of Vietnamese adults and elderly?

(b) In what ways does the American healthcare system improve their health? In what ways does it harm it?

3. How could the American healthcare system be better integrated into Vietnamese Traditional Healthcare?

(a) Can biomedicine and folk medicine integrate with each other?

(b) Can healthcare workers provide culturally sensitive healthcare when working with Vietnamese clients?

4. What role can education play in improving access to healthcare for Vietnamese adults and elderly in Greater Springfield?

(a) How do Vietnamese adults and elderly need to be educated about the American healthcare system?

(b) How do American healthcare providers need to be educated about Vietnamese culture?

This research is based on the qualitative approach of in-depth interviews with 14 Vietnamese people, participatory observations, and case studies available to the researcher in the Vietnamese community of Greater Springfield.

Definition of Terms

Access problems. Difficulties occur when the Vietnamese adults and elderly try to become involved in the American healthcare system.

American healthcare system. Health services are institutionalized in America, including health policy, organization, administration, and access or delivery.

Belief. Vietnamese adult and elderly people have healthcare practices and folkways that they think are effective.

Biomedicine: "Medicine based on the application of the principles of the natural sciences and especially biology and biochemistry" (Merriam-Webster's College Dictionary, p.115).

Client. American health providers deliver health services for Vietnamese adults and elderly, and these Vietnamese become health providers' clients.

Culturally sensitive. American health providers, when working with Vietnamese clients, must know their culture and emulate appropriate cultural manners with them.

Encounter. When accessing healthcare in America, Vietnamese adults and elderly must overcome many problems including conflicts with the way the American healthcare system functions.

Folk medicine. "Traditional medicine as practiced non-professionally, especially by people isolated from modern medical services, and usually involves herbal remedies on an empirical basis" (Merriam Webster's College Dictionary, p.452).

Improve. To augment values, quality, and/or quantity of healthcare.

Integrate. The American healthcare system and Vietnamese traditional healthcare blend together to improve healthcare for Vietnamese of Greater Springfield.

Level of involvement. How often participants use the American healthcare system, what the problems they deal with are, and where they receive care.

Traditional. Vietnamese have unwritten customs, habits, and beliefs that are passed on from generation to generation.

CHAPTER II

LITERATURE REVIEW

This chapter reviews relevant literature and empirical research as a basis for understanding the role of cultural influence on healthcare for Vietnamese adults and elderly. I will look at different aspects of the Vietnamese healthcare experience in the United States: Health problems, health culture, traditional health practice, health utilization, and health education. I examine a theoretical framework to explain which conditions or factors influence Vietnamese adults and elderly to adjust or assimilate from their own to the American culture.

Through reviewing the literature, we see both the positive and negative aspects that Vietnamese adults and elderly deal with when accessing healthcare in the American system.

Theoretical Framework

To study Vietnamese adult and elderly healthcare in the United States is to attempt to understand their health culture and acculturation. Much research has been done on refugees' and immigrants' acculturation in America and this research has generated many theories, models, and approaches.

Culture is defined as a tradition of customs, norms, and lifestyles of individuals or groups. Health and illness, as well as healthcare, belong to culture. Through culture, people can accept some kinds of illness, or some patterns of health treatment (Ma, 1999). Acculturation is "Cultural modification of an individual or group by borrowing and

adapting traits from another culture " (Merriam Webster's College Dictionary, p.8), a result of cultural exchange through contact between two cultures, one dominating over the other (Social Science Research Council [SSRC], 1954). When acculturating, people may overcome many difficulties, conflicts, and reactions in different ways, such as assimilation, adjustment, rejection, or opposition. By acculturation, people will live in a society, through pluralism, a "melting pot," or segregation (Berry, 1980). Because acculturation is a complex concept requiring many fields of study such as sociology, anthropology, and psychology, any single theory is not enough to study all levels of acculturation.

Model of Acculturation Theory

There have been many studies of the acculturation of refugees and immigrants. In a study of refugees and immigrants adjusting to a new country, Padilla (1980) said individuals or groups could be acculturated more or less effectively to the host culture depending on their own cultural awareness. If the newcomers have more cultural awareness of their own culture, they will be less acculturated in the host country. The Chinese, for example, are less acculturated in the host country because they have more cultural awareness (Rutledge, 1992).

In addition to cultural awareness, it is hard for any group of people who are acculturated in the host country if they are deeply involved in their own cultural activities. Although having deep knowledge and many cultural activities in their own culture, individuals may be acculturated more or less in their host country depending on their cultural preference. If they like the host culture, they will become more acculturated. Acculturation also depends on the length of time the person lives in the host country.

Individuals who have lived for a long time in the host country will be more acculturated than those who have lived there for a shorter time. The younger generation acculturates faster than the older generation. Acculturation also depends on language proficiency. Those who speak the host language fluently will be more adapted to the new culture. For example, one study found that Southeast Asian children learned English faster than their parents and were more Americanized than their parents (Heasche, 1986). Likewise Hispanics who spoke English fluently used more preventative healthcare services than those who did not (Amaro et al., 1990). Chinese who spoke English well involved themselves more actively in the American healthcare system than those who could not speak it (Loo et al., 1984).

Acculturation can change an immigrant's lifestyle and diet, which also causes poor health outcomes. Hispanics who lose their traditional diet have greater risk of breast cancer, prostate cancer, and colon cancer, as well as becoming heavier smokers, drinkers, and drug users, than those who do not (Flack et al., 1995). Latino children who live for a longer time in America have less immunization than those who live here for a briefer time (Anderson et al., 1997). . Sue et al (1995) stated that Asian American students who were less adjusted to American culture had more psychological problems than students who had more acculturation.

Acculturation also has a relationship to alcohol drinking and smoking. Those who have more cultural stress also have more alcohol consumption in the host country. Acculturation increases heavy drinking in young immigrant groups and decreases abstention among older groups (Caetano, 1987). The young Chinese American drinks more alcohol than new Chinese immigrants (Sue et al., 1979). More acculturated

Japanese are five times more likely to have coronary heart disease than those who are less acculturated (Marmot & Syme, 1976). Acculturation increases diabetes and obesity in minority groups. Acculturated Mexican American women have more risk of diabetes (Hazuda et al., 1998).

Education and income influence acculturation. The more educated individuals are, the more acculturated they are. Low-income immigrants are slow in healthcare access because they do not have enough experience or information (Strauss, 1988). Mexican Americans with low incomes were much more obese than those with high incomes (Huff & Kline, 1999). Poor nutrition, limited healthcare access, and the lack of preventive healthcare are related to low education levels and economic status (Johnson et al., 1995).

Finally, acculturation depends on the amount of ethnic interaction. People who live in ethnic communities and have little contact with outsiders will be less acculturated than those who have more interactions. Chinese immigrants are slower to acculturate because they like to live in a "Chinatown," separated from the outside world. Meanwhile Japanese immigrants are more quickly acculturated and assimilated because they are more involved in the host country (Rutledge, 1992).

Behavioral Model of Health Utilization

Culture influences the behavior of the individual. The environment influences individuals who grow up or live in that environment. According to Anderson (1995), such factors as politics, economics, social change, which are called external components, influence individuals or groups in healthcare involvement. For instance, due to an economic depression, the government has cut its healthcare budget, so recipients have had their available healthcare services limited. Purnell and Paulanka (1998) stated that

natural disasters, wars, and political crises force people to alter their lifestyles. Another factor that influences acculturation in healthcare services is characteristics of the subject population, which are based on predisposing, enabling, and health need components (Ma, 1999).

Predisposing components include demographics (sex, age, family size) and social structure (education, religion, and employment status). For example, individuals who get a good job, good benefits, and good health insurance coverage will have more healthcare access than those who do not. Predisposing components also include barriers to access; for instance, getting appointments to see the doctor, lack of transportation, the relationship between provider and client, and language problems. Those who have convenient transportation will visit their doctor more times than those who do not. Enabling components are those that provide the means for getting health services, such as a higher income and health insurance. Women with low incomes are not actively involved in Pap smear and cervix screening (Aday et al., 1984). The acculturation of immigrant Latino women and blacks depended on their level of education and income (Balcazar et al., 1995; Zelasko, 1995). In a survey in Los Angeles County, half of the Korean Americans did not have health insurance because of high cost and the lack of time to visit the doctor (Huff & Kline, 1999).

Health needs are "conditions requiring supply or relief" (Merriam-Webster's Collegiate Dictionary, p.775) appropriate to the level of health. Individuals use healthcare depending on their needs, level of illness, and based on a healthcare provider's evaluation (Eve, 1988).

In American healthcare systems, health policy plays an important role in acculturation. Health policy designs the structure and strategy for everyone in the system, and provides programs for the clients. It contributes greatly to altering healthcare access. Healthcare delivery systems, including resources and organizations, provide all the necessities for getting healthcare access, such as labor, finance, and administration.

Depending on the illness, the site, purpose, time of the visit, and the behavior of the health provider, individuals will be more or less willing to use Western healthcare. The site is the place where individuals get health services such as a clinic or hospital; the equipment is the means to access healthcare. People go to a clinic much more if the clinic is near their house and has modern equipment, which makes them feel safer. Good doctor-patient communication increases the quality of healthcare access. A health provider who understands the clients in their cultural styles will make the clients feel more at home, and make himself more trusted by them. Client satisfaction increases healthcare access. It refers to the attitude of individuals after they use healthcare. If individuals are satisfied with the cost, the healthcare provider's behavior, and the equipment, they will become more involved in healthcare (Aday et al., 1978).

Healthcare System Model

In a pluralistic society where many different cultures are highly esteemed, a unilateral healthcare system cannot fully respond to the healthcare needs of individuals or groups of different cultural backgrounds. People respond to their health access opportunities according to their culture. Kleinman (1978 a) conducted the healthcare system model to understand health behaviors and health illness in a multicultural society. There are different ways for individuals to be involved in healthcare access, and therefore

there are different sectors in healthcare. The healthcare system model is a cultural system because it reflects people's reactions to healthcare treatment from within their cultural context.

The healthcare system model consists of three social sectors - The popular, professional, and folk sector, which is related in their goals to improve healthcare. Depending on their health needs, people can use all three sectors, or only one, or some combination. Each sector has its own cultural construction of illness, screening examination, treatment techniques, management, healthcare practitioners, and methods of evaluation.

Popular Sector

The popular sector is the first and most comment for access to the healthcare system. It is based on the individual, family, and community. It is an entrance for people to become involved in healthcare, where any symptom or illness is first diagnosed, and then the client is given the decision to treat or not. In response to illness, self-care or healthcare practice is encouraged in the family and in the community, before involving Western or traditional healthcare. It exists not only in Western but also in non-Western countries, and is the largest sector in healthcare because about 70% to 90% of illness is treated in this sector. The popular sector of the healthcare system is highly esteemed in the Chinese community. Ma (1999) said that among 52 Chinese interviewed, 96.2% used self-treatment and home remedies for their personal healthcare.

The popular sector is a way to maintain health. It permeates daily activities to improve the condition of health, such as wearing warm clothes in the winter, short-sleeved shirts in the summer, or sunglasses in the sunshine (Eisler & Hersen, 2000).

Professional Sector

The professional sector is usually the Western healthcare system, or any system, which is organized and structured with research and experimentation in advanced technology to improve healthcare. Nowadays, by its effectiveness, this sector, in which Western healthcare is dominant, has spread to most countries around the world. In this sector, health treatment emphasizes biomedicine and chemotherapy, and it is effective in treating many fatal diseases, such as AIDS and Hepatitis B. The means to treat illness are based on laboratories, ultra sound, and X-rays, which are meant to be precise and effective. The doctors, nurses, and specialists in Western medicines are trained in and respond to many diseases.

Folk Sector

In contradistinction to the professional healthcare system is the folk sector or traditional healthcare sector. The traditional sector is not as structured and organized as the professional sector, but rather depends on the experiences of predecessors or ancestors, and is transferred from generation to generation. Traditional health strategies and evaluations do not place emphasis on experiments or laboratory work, but on the spirit, nature, religion, and superstition. Traditional health practitioners are herbalists and non-professionals such as healers and clergymen. They are required to be trained for a period of time by predecessors or learn from the experiences of ancestors. The folk sector is rather popular with ethnic groups, and especially among Asians and Hispanics. Dean (1998) said that many Mexican Americans treat health problems by folk medicine (Curandero), because they believed their illnesses are caused by the imbalance of bodily elements.

In a study of 54 black females from 45 to 70 years old, Heurtin et al. (1990) found that folk beliefs influenced their compliance in hypertension treatment, and that those who understood their health problems as belonging to biomedical disease complied poorly with the treatment (27%), compared to those who believed it stemmed from the blood being too hot or too thick (63%).

According to Ma (1999), only 46% of Chinese in Houston, Texas, went to U.S clinics, but 75% used traditional Chinese medicine daily in the form of various types of herbal teas, including ginseng, *tang-gui*, and *ju-hao*. Even cooking foods with herbs is popular in Chinese families. Despite living in the United States for long periods of time, Korean elders in Chicago still seek healthcare from traditional providers (Yu et al., 1990). In Detroit, 24% of women and 10% of men used folk treatments for hypertension (Bailey, 1991). Rivera (1988) said that 32% of Mexican Americans in an urban area in Colorado sought healthcare from Curandero (Mexican folk medicine). Despite the prominence of biomedicine, folk medicine persists and even thrives in the United States (Baer, 2001).

The above-mentioned cultural and behavioral models are selected as theoretical frameworks in this study of Vietnamese healthcare in Greater Springfield. Each theory has its own tools and methods to analyze how Vietnamese use healthcare in America.

Vietnamese in America and Cultural Adaptation and Acculturation

The Vietnam War ended in 1975 after 16 years of struggle between North and South Vietnam. The Vietnam War caused millions of South Vietnamese to flee their country and go to the U.S.A. and 40 other countries all over the world to avoid the discrimination of the Communist regime. At least 614,547 Vietnamese refugees and

immigrants came to the U.S.A from 1975 to 1996 (US Bureau of Census, 1996). They came to America in many waves and from different educational backgrounds.

Waves of Refugees

The first wave of 130,000 Vietnamese refugees to come to the United States left immediately after April 30, 1975. Most refugees in this wave were professionals, Catholics, highly educated, officers of South Vietnamese government, had lived in urban areas, or had worked with the American army. The second wave of refugees, who were relatives of the first wave, came to America from 1975 to 1978. They included those who had worked with the South Vietnamese government, or with the American army, or were old officers who had been in the South Vietnamese army, as well as the Chinese Vietnamese who were discriminated against by the Communists in the economic reform campaign in 1977. The third wave of refugees came to America from 1978 to 1989. After Congress passed the Refugee Act of 1980 (Lynch & Hanson, 1994), permitting Southeast Asians to resettle in America, hundreds of thousands of Vietnamese fled their country to America. Most were from rural areas or coastal cities, and fled by different routes: on the ocean as "boat people" to the reception camps in Singapore and Indonesia, or on foot across Cambodia to Thailand. These people had a hard time adjusting to American society because of their limited educational backgrounds.

When the number of refugees had increased, and because of the danger of fleeing the country on the ocean or through the jungle, the United Nations encouraged Vietnamese refugees and immigrants to leave their country in the Orderly Departure Program (ODP). Thousands of Vietnamese people participated in this program from 1989 to 1998, including political detainees and Amerasians, whose fathers are Americans and

mothers are Vietnamese. (To qualify as a detainee, one must have been an officer or soldier of the South Vietnamese army and have been reeducated in the concentration camps for at least three years [Lynch & Hanson, 1994]).

Nowadays, the Vietnamese population in the United States is more than 1.2 million (Ly et al., 2000). Initially they dispersed across the country; but later on they concentrated in three states: California, Texas, and Louisiana. Since 1975, Massachusetts has received more than 40,000 refugees from Vietnam (Massachusetts Refugee and Immigrant Health Program, 1998). They are mostly concentrated in Boston and Worcester with a smaller number in Springfield, and contribute significantly to American society.

Adjustment and Assimilation

Much research has been done on the adaptation and acculturation of the Vietnamese. Adjustment and acculturation to the host country are problems for any new arrivals. Vietnamese refugee and immigrant adjustment to American society is not easy, and many factors, such as their psychological, social, and economic problems, are likely to hold back the adjustment process. In their own country, they had been discriminated against by the Communist regime; on the way to America, they had confronted many dangers, such as from pirates or hunger; and in the new country, they have to live in a different culture from their own. In particular, many factors prevent Vietnamese refugees and immigrants from being successfully involved in the American healthcare system.

Language Barrier

Language is a problem for Vietnamese refugees and immigrants because it is necessary for any person to know the English language to be involved in American

society. Language barriers limit mutual understanding between patients and health providers. Although Vietnam was influenced by American culture from 1960-1975 during the Vietnam War, in which many Vietnamese worked with the American servicemen, most Vietnamese coming to America could not speak English, or could not speak English fluently. In a survey conducted in 1983 by Haines (1989), only 8.6% of Vietnamese entering America could speak English fluently. Another study (U.S. Department of Commerce, 1993a, 1993c) also showed that 65% of all Vietnamese five years of age or older could not speak English fluently. In San Diego, Rumbault et al., (1988) found that nearly 62% of Vietnamese could not access healthcare because they did not speak English. Even those who had lived in America for a long time, and had learned some English, did not perform well in psychiatric interviews (Lin & Shen, 1991).

Family Values

Influenced thousands of years ago by Confucius, a Chinese philosopher, Vietnamese people have high family values. Vietnamese families are typically male-dominant, in which the husband is the head and has more power than the wife. An individual is not more important than his or her family (Nguyen, S., 1982), and children must obey their parents. The Vietnamese family is also an extended family unit where the father, mother, children, and grandparents all live together in the same house. The father or elders make absolute decisions for the family on issues such as education, economics, and healthcare. In healthcare, the father can choose the primary doctors for his family, and make final decisions for his children on treatment, such as surgery, or preventative measures. As a result, healthcare access for the family is a problem if the father or elders keep traditional healthcare values and do not want to be involved in American healthcare (Ho, 1992).

Economics

Economic status influences healthcare access: if people have adequate income, they also have health insurance. Research shows that those who have health insurance are likely to be healthier than those who have no health insurance. Unfortunately, like other ethnic groups, most Vietnamese refugees and immigrants are in low-income brackets. Because of their limited job skills, they only get jobs with low salaries and positions of low skill level, which offer little or no health insurance. In Ohio, for instance, only 3.5% of Vietnamese worked in technology and in government, while 40% are Vietnamese laborers (Haines, 1989).

In 1998, when the 1994 federal poverty level for one person was $7,500, $9,000 for a couple, and $14,000 for a family of four, and the near poor level was $33,320 for a family of four, 46.6% of Vietnamese in the United States were either poor or near poor. (Camatora & Edwards, 2000).

Education

It is obvious that health status is closely related to education: the more educated they are, the more likely people will be to get good jobs. Those who have little education are likely to get jobs with fewer benefits and less health insurance coverage. In 1998, 27.1% of Vietnamese in the United States had not received a high school degree, compared to 9.1% of Indian Americans, 12% of Philippine Americans, and 19% of Chinese Americans (Camatora & Edward, 2000). By 1990, 68.5% of Vietnamese in the United States at age of 25 or older had high school-level education. Also in that age group, 12.2% of Vietnamese women and 22.3% of Vietnamese men had four years of

college, as compared to 23% for women and 23.5% for men in the general U.S population (U.S. Department of Commerce, Bureau of Census, 1993 b).

In general, Vietnamese in the United States have difficulty adjusting to American society, because there are many barriers such as language differences, low economic status, and low levels of education.

Health Problems

Illnesses come from many different causes, ranging from malfunction of the body, dieting and behavior (alcohol consumption, lack of exercise), nature (earthquakes, bacteria, viruses), to society (stress, conflict) and the supernatural (god, ancestor) (Helman, 1984). Vietnam is one of the countries in Southeast Asia with a high frequency of communicable diseases. Many Vietnamese refugees and immigrants, when coming to America, have been infected with tuberculosis, anemia, malaria, and hepatitis B (Hoang & Erickson, 1982; Muecke, 1983b).

Smoking

Smoking is a risk factor for cancers, coronary heart disease, and strokes. 87% of all lung cancer is from smoking (American Cancer Society, 2001). Smoking is a problem in the Vietnamese community. The smoking percentage of Vietnamese males in America is 54%, versus 37% for Japanese, 28% for Chinese American and 20% for Filipinos (Han et al., 1998). But Vietnamese women rarely smoke; only 9% of Vietnamese women smoke, compared with 27% of American women. Vietnamese males smoke at a high rate because they are in low income brackets, have language barriers, have been in the United

States for a short period of time (nine years or less), have acculturative stress, and are naïve about the health risks (Jenkin et al., 1990).

Tuberculosis

Vietnam is a high-risk country for tuberculosis (TB). Every year, about 145,000 people are infected with TB (VNN, 2003). In America, 69% of Vietnamese were infected with TB germs already when they came (Cazaro & Moser, 1982). The Vietnamese TB percentage rate is 40 times higher than the general U.S. population (Huff & Kline, 1999). In Massachusetts, although Vietnamese only comprise 1% of the population, they had 10% of all new TB cases in 1990 (Massachusetts Refugee and Immigrant Health Program Manual, 1998). From 1993 to 1998, out of 1,094 foreign-born TB cases in Massachusetts, Vietnamese had 184 cases, or 17% of the total (Riemers et al., 1998).

Mental Health

Having lived through the Vietnam War, political imprisonment after the Vietnam War, and the brutal confrontations with pirates when fleeing their own country, Vietnamese are easy prey to anxiety disorders and post-traumatic stress (Hinton et all, 1993). The Vietnamese have a high risk of having or developing mental health problems in America. At least 117 Vietnamese mental health cases, in which the victims died suddenly without explanation, were found from 1981 to 1988 (Center for Disease Control, 1990). In 1989 the Massachusetts Department of Mental Health confirmed that 48% of Vietnamese who settled in Massachusetts had been robbed or tortured during their escape. Fifteen percent of Vietnamese who settled in California had symptoms of severe mental health problems (Lee, 1986). There are many other reasons for mental health problems for Vietnamese. In addition to living long periods of time in the refugee

camps in Singapore, Indonesia, and Philippines, and being raped or enduring hunger on the ocean, they suffered from culture shock, unemployment, the generation gap, and language barriers, (Lynch & Hanson, 1994).

Hepatitis B

Vietnamese refugees and immigrants are at high risk of Hepatitis B (Hep B). Hep B carriers among Vietnamese are from 5% to 15% of the population, compared to 0.2% for the general US population (Frank et al., 1989). In Massachusetts, nearly 12% of Vietnamese were infected with Hepatitis B virus. Liver cancer can be caused by viral infection. Without Hepatitis B vaccination, the Hepatitis B carrier mother will infect 90% of newborn children (Massachusetts Refugee and Immigrant Health Program, 1998)

Vietnamese and the American Healthcare System

Although their own health culture is so different, Vietnamese are also involved in the American healthcare system. In contrast to many other countries in the world where people are covered by health insurance provided by the government, the majority of the U.S. population receives health insurance coverage through the private sector. In the world today, only in South Africa and in the U.S.A. does the government not cover health insurance (Spector, 1996).

American healthcare has public and private programs. Among public programs, there are Medicare and Medicaid: two major publicly-funded healthcare programs covering healthcare for 80 million Americans. While Medicare provides healthcare services for elderly 65 years or over, Medicaid is for the poor. In 1997, Medicaid covered 41 million Americans and spent $160 billion on healthcare services.

In private health programs, 61.4% of Americans are insured by groups and health plans related to employment coverage, and 8.75% purchase health insurance on their own. Americans have spent 14% of the U.S. Gross Domestic Product (GDP) on healthcare plans. In 1997, $1.1 trillion was spent for healthcare, of which the public sector spent 46%. Nowadays, the American healthcare system emphasizes managed care, which limits the cost of health services for patients and health providers alike. HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations) have developed very quickly (Craig, 1999). Vietnamese and other ethnic groups consider American healthcare complicated. Providers require complex paperwork from patients, elaborate testing procedures, and have many policy regulations (Gou, 1994).

Discrimination

Many Vietnamese experience discrimination when accessing healthcare. In the King County Ethnicity and Health Survey (1996), 39% of the respondents reported they felt discriminated against by gender, race, economic position, or social class. 70% of Vietnamese respondents who reported they had been discriminated against were also more likely to report a delay in seeking healthcare, compared to 60% of Koreans who reported being discriminated against and only 25% reported a delay in seeking healthcare (Public Health Special Report, 2001).

No Health Insurance

Compared with other Asians in America, Vietnamese have one of the largest percentages of their total population with no health insurance. The percentage of the population that lacks health insurance is 26.7%, or 335,000 out of 1,254,000 Vietnamese. Thus, the Vietnamese are second only to Koreans (45%) in the number of Asian

American people who are without health insurance coverage. As for Medicare and Medicaid, 16.5% of Vietnamese received Medicaid, compared to 29.5% for Russians, and 36.1% for Dominicans (Camarota & Edward, 2000).

Under-Utilization of Healthcare Services

Vietnamese refugees and immigrants are likely to under-use healthcare services compared to the general population. Purnell and Paulanka (1998) said that 28% of Vietnamese women in the San Francisco area never had a breast examination and 83% never had a mammogram in their life. The Southeast Asian Health Project in 1990 conducted an interview of 117 Vietnamese women about how and when they go to the doctor if they or their family members are ill. Sixty-two percent of them would consult doctors, 60% would visit an emergency room, 24% would visit children's clinics, 20% would visit a clinic or hospital not requiring a scheduled appointment, 7% would consult monks or spiritual leaders, and 6% would use over-the-counter drugs (Lew, 1989). In 1994, 47% of the Vietnamese did not receive blood work or a Pap smear when visiting the doctor (Commonwealth Fund, 1995). Many Vietnamese believe Western medicine is strong and effective, but do not recognize the risks of using medicine if overdosed or under-dosed (Purnell & Paulanka, 1998). Therefore they do not use prescribed medicines appropriately. In addition, they share medicine with family members if anyone has the same symptoms.

Being scared of side effects, some Vietnamese like to adjust their dosage to the level they think is good, because they think their body is thinner and shorter than an American's. They may stop taking the medicine altogether if their symptoms disappear (Muecke, 1983 b).

Family Values

In Vietnamese culture, the family must try to resolve every problem within the family before seeking help from the outside. For illness, the members of a family try to self-treat, self-medicate, and generally care for themselves as much as possible. If the conditions become serious, they will go to the doctor. Vietnamese only go to clinics, hospitals, or emergency rooms when everything else fails (Gold, 1992).

In short, American healthcare is different from Vietnamese healthcare. When adjusting to American healthcare, Vietnamese must overcome many obstacles because of cultural differences.

Health Education

Health education has a significant role in accessing healthcare successfully for Vietnamese. Those who understand the importance of healthiness will actively involve themselves in healthcare. Many studies indicate a lack of education for Vietnamese in healthcare, which in turn decreases the amount of healthcare services sought. In a study conducted by Chen et al., (1991), 85% of Vietnamese did not know how to prevent heart disease. As for hepatitis B, a high-risk disease in Southeast Asia, many Vietnamese who were infected before coming to America do not understand what hepatitis B is, or how to prevent it (Jerkin et al., 1990). In response to problems caused by the lack of health education, many more programs are being designed to improve the health and physical condition of Vietnamese.

Suc Khoe La Vang (Health is gold) was a health education program for Vietnamese in San Francisco Bay area. In 1992, although 36% of Vietnamese males in

San Francisco were smoking, one quarter of them did not know smoking causes cancer (Jenkins et al., 1990). In response to this lack of health education, *Suc Khoe La Vang* aimed to decrease the number of Vietnamese smokers by publishing newsletters, magazines, and videotapes with anti-tobacco articles. Other Vietnamese written materials such as Vietnamese New Year calendars and bumper stickers were also distributed to the community or in Vietnamese market stores. Additionally, health education programs were shown on television, advertised in newspapers and magazines, and presented by staff in community events such as the New Year festival and Christmas. In addition, 68 Vietnamese doctors participated in the smoking cessation counseling method training, and two public schools in San Francisco and Oakland volunteered to participate in the program (Balderson, 1992; Le et al., 1994). The result was considerable. On post-test, the number of current smokers decreased from 38.7% to 33.9%, and the number of smokers quitting increased from 7.2% to 10.2% (Jenkins et al., 1997).

"Pathways to Early Cancer Detection for Vietnamese Women" was another program in San Francisco and Sacramento for breast and cervical cancer screening and prevention. It was offered at the same time as *Suc Khoe La Vang*. This program was based on neighborhood-based intervention, using outreach health education to improve disease prevention. To assist the program, ten lay health workers and many health assistants worked in groups, encouraging people, friends, and relatives to participate in screening and prevention. These groups made people get involved in health education by having a presentation of about 15 minutes for disease prevention, then a facilitated discussion with questions. All groups worked in private residences, especially small groups in family and community health fairs. Many cultural Vietnamese written materials

were distributed to the participants and Vietnamese physicians. To be effective in training, program staff and health workers were trained in presentation and discussion. To test the effects of intervention pre-tests and post-tests were conducted for 306 Vietnamese women in San Francisco in the experimental community and 339 Vietnamese women in Sacramento in the control community. The result was that the stage of Pap Smear Test Behavior is 56% for Sans Francisco and 62% for Sacramento in Precontemplation and Contemplation; 9% for San Francisco and 10 for Sacramento in Action; 24% for Sans Francisco and 21% for Sacramento in Maintenance (MacPhee et al., 1996).

Vietnamese and Traditional Health Culture

Like other Asian Americans, Vietnamese refugees and immigrants have cultural health concepts and health practices different from those of the people in Western countries. Traditional healthcare always keeps in touch with nature, and considers any human being as a unit of body and soul. It has two components: southern medicine (*Thuoc nam*) and northern medicine (*Thuoc bac*).

Vietnam is located in a tropical area where hot temperatures and high humidity create good conditions for forest and animal survival. Vietnam has more than 300 species of mammals, 1000 species of fish, and many kinds of reptiles, amphibians, insects, and domestic animals. Vietnamese know how to produce medicine appropriate to their climate and tropical area. In primitive times, Vietnamese ancestors had already used plants and herbs including leaves, fruits, and wood for medicine.

There are many legendary stories relating to the traditional healthcare of the Vietnamese. Chewing betel with areca nut and lime has been a custom for thousands of

years in Vietnam. During the Hung dynasty (1st century BC), there were three young people: a man, his wife, and his brother. By mutual misunderstanding, they all died for each other's love; then transformed themselves into an areca palm tree, a betel plant, and limestone. To memorize this eternal love, people use betel leaves, areca nuts, and limestone as symbols at the receptions of marriage and ceremonies (wedding, offering). They are also used for dental cleaning, breath sweetening, and especially for protection from tooth decay.

In addition to the betel and areca story of the custom of blackening of teeth, there is another story of Cuoi in the moon, which treated his illness with leaves in the forest. This is a traditional folkway to improve general health. During the reign of An Duong Vuong of the Thuc dynasty (3rd century BC), Vietnamese used *moxa*, a method to warm the body to treat illness. Ginger, pepper, cinnamon, salt, and onion have been used in Vietnamese traditional health maintenance for thousands of years (Hoang et al., 1999).

Southern Medicine (*Thuoc nam*)

The founder of southern traditional medicines was Tue Tinh (14th century), a monk and a physician. After mastering all the Chinese medicine, he applied it to southern medicine, which is not based on five elements of Chinese medicine (metal, wood, water, fire and earth) but on the local plants, herbs or animals in Vietnam. His healthcare strategies did not follow Chinese medicine because Chinese medicine uses too much ginger and cinnamon, not appropriate to Vietnamese in the tropical climate (Hoang et al., 1999). Tue Tinh's follower was Hai Thuong Lang Ong. Born in the 18th century, he knew how to apply the theories of Taoism and Confucius to medicine. He strengthened Tue Tinh's medical concept of the difference between the hot climate of Vietnam and the cold

climate in China, and recommended using onion and ginger for medicine (Do tat Loi, 1999).

Northern Medicine (*Thuoc bac*)

Chinese medicine existed for a long time in Vietnam, not only during the 1,000 years of Chinese domination, but also after Vietnamese independence (939) and until the French colonization (1898). However, until the present, Chinese medicine has also had an important role in Vietnamese healthcare as a whole. Like southern medicine, northern medicine uses nature as a means of treatment, specifically, by using medical plants and herbal vegetables.

Traditional Healthcare

"Hot" and "Cold" Theories

The human being is a creature who cannot be separated from the universe. In the beginning, the "*Vo Cuc*" (absolute Nothingness) transformed into "*Thai Cuc*" (Great Absolute) in which appeared the "*Am*" (Cold) and "*Duong*" (Hot). The concept behind "*Am*" and "*Duong*" is not temperature, but an inconsistency between things. It represents the contrary phenomenon, which controls the transformation and development of the object. The transformation system includes fighting each other, supporting each other, and encouraging each other to advance. The "*Am*" principle is female, negative; the "*Duong*" principle is male – positive, bright. "*Am*" and "*Duong*" govern human beings, nature, and the universe in every activity, and balance everything, even if everything is in turmoil (Hoang et al., 1999; Do Tat Loi, 1999).

The forces of "*Am*" and "*Duong*" in the universe have influenced Vietnamese

healthcare and health behavior. "*Am*" and "*Duong*" exist in any living object. People are healthy when they have a balance between "*Am*" and "*Duong*". If the body is too "Hot," it must be balanced by "Cold"; the medicine plant or grass belonging to "Cold" can treat the patient. Herbal plants or grasses that belong to "Hot" live in the shadow, under other trees. Their characteristics are warm, hot, and help the body to be strong. On the other hand, the plants that belong to "Cold" live in the sunshine. To be healthy, the idea is to give priority to the natural defenses of the human body and strengthen them in balance (Do tat Loi, 1999).

The "*Am*" and "*Duong*" principle not only influences Vietnamese perceptions of health but also has an effect on food in health treatment. Vietnamese believe that diarrhea is the result of eating too much cold food. Rice, fish, duck, most fruits and vegetable, and anything that grows in water are cold foods. Meat, ginger, and pepper are examples of hot foods. Because diseases are caused by the imbalance between "Hot" and "Cold," Vietnamese like to self-treat using this concept. For example, if a child has a stomach ache, he needs to examine his diet. If he has eaten too much hot food (meat) he needs to adjust it by eating cold food such as vegetables and rice (Purnell & Paulanka, 1998).

Wind (*Phong*)

"Wind" is a noxious element that penetrates the human body and causes disease. Like "*Am*" and "*Duong*," "*Phong*" is part of nature. There are many noxious "Winds" penetrating the body if it is not taken care of. Certain foods, such as chicken, can cause disease because they contain "Wind." To be healthy, people need to remove "Wind." To exclude "Wind," Vietnamese use many methods: coining, burning, and spooning, even avoiding eating certain food such as beef and duck meat (Buchwald et al., 1982).

Religious Beliefs

Ancestral worship is important in healthiness. Vietnamese believe that, although they have passed away, ancestors will continue to live with their families, assisting and protecting them in daily life. Ancestral spirits, gods, demons, and other spirits influence the health condition. If anyone commits a wrongdoing, his ancestors, gods, and demons will punish him; disease is the result of gods, demons, and other spirits' punishment. As a result, people often attend church or temples for healing (Lynch & Hanson, 1994). Religious belief plays an important role in Vietnamese health belief, behaviors, and practices.

Buddhism

Buddhism is the main religion in Vietnam. Buddha encouraged people to embrace their sufferings. Life is full of problems caused by desire or ambition, and disease is one of those problems. Suffering, even suffering from disease, is a means of purifying one's soul and maintaining good health (Hoang & Erickson, 1985).

Confucius

Confucius, a Chinese philosopher who influenced Vietnamese culture a thousand years ago, emphasized the hierarchy in a society. Individuals who fulfill their responsibilities toward family, society, and themselves will be happy and healthy. Harmony in family and society is a good way to have good health. Therefore, the father or oldest in the family is honored and has final decisions on family matters.

Taoism

Contrary to Confucius, Taoism advises people to avoid being involved in society, but to blend into nature. Healthiness is a way of life, not just an absence of disease. If

people involve themselves in nature, their soul and mind will become pure, and nothing can bother them; thus, they will be healthy. The means to enter nature is meditation. Taoism encourages people to practice meditation to achieve a healthy life.

Catholicism

Catholicism was introduced in Vietnam during the 16th century. Although it is a minority religion in Vietnam, many Vietnamese refugees and immigrants are Catholics, or have been influenced by Catholicism because of attendance at Catholic schools in Vietnam. The Vietnamese Catholics, by their doctrine, have family planning difficulties because all forms of abortion and out-of-wedlock pregnancies are strictly forbidden (Lynch & Hanson, 1994; Hoang & Erickson, 1985).

Healthcare Practices

In traditional healthcare, Vietnamese follow these health practices:

Coining (*Cao gio*)

Coining is a method to treat colds, fevers, and headaches. The procedure consists of spreading traditional oil over the area of pain, and then scratching the edge of a coin over it with short strokes (usually located on the neck, back, or forehead), If a dark blood appears under skin, the ill person had a "bad wind," which means, he is really sick. Coining is used to pull "Cold" out of the body. Once the "Cold" is out, the patient will return to normal health (Schreiner, 1981).

Pinching (*Bat gio*)

Pinching is another form of coining. The procedure is the same principle as coining. However, the index finger and thumb are used for pinching on the painful area

instead of the coin several times. Pinching is performed mostly on the neck, the forehead, and between the eyes. If a person had acquired "Cold," the dark red blood would appear under the pinched area. Like coining, pinching cures headache, blurred vision, and fever.

Cupping (*Giac hoi*)

Cupping is the way to pull "Cold" out by suction. Cupping is popular in among Vietnamese, and is even used by many Chinese. The procedure requires placing alcohol-soaked cotton balls inside the cups, igniting the balls, and then placing the cups on the painful area. The created air vacuum will pull the skin inside the cup and all bad winds will be removed. Cups are taken off after 5 to 10 minutes. Cupping is mostly used for the treatment of back pains and headaches. It is appropriate for adults, but sometimes may also be used for teens (Hoang & Erickson, 1982, Schreiner, 1981).

Burning (*Dot*)

Like other health practices, burning is used to pull "Cold" or "Wind" out of the body. Burning is rarely used because the procedure is too complicated and requires professional skills. One must ignite a dried weed like grass dipped in hot melted pork lard and then apply it to the treatment area (usually on the abdomen). Burning treats any kind of pain, even pain from diarrhea.

White Tape (*Cao gian*)

Vietnamese like to use white tape to treat fevers, colds, and especially headaches. The white tape infused with oil is adhesive on the forehead, the breast, the shoulders, the back, or any painful area to clear the "Wind". Usually the tape is changed every 24 hours, until the patient feels better (Schreiner, 1981)

Herbal Steam (*Xong*)

Herbal steam is convenient because it does not create more pain for patients such as in coining or cupping. It also makes the "bad wind" exit the whole body. Medical herbs, which include ginger, lemon grass, orange peels, and ginger, are put into boiling water pan and the vapor is inhaled. The patient should inhale the vapor with the whole body covered in a blanket for about ten minutes. All "bad winds" will leave and the ill person will feel better. Herbal steam treats colds and fevers (Giger & Davidhizar, 1999).

In addition to traditional health practices, Vietnamese also use balms and oils of brands like "Red tiger' and "Mac Phu" to treat colds, fever, and headache. Red tiger and Mac Phu are used temporarily because they are convenient, but are less effective than other traditional health practices (Buchwald et al., 1992).

Traditional Healthcare Usage

Traditional healthcare practices still remain popular in the Vietnamese community throughout the United States. In a study, Silverman (1980) found that Vietnamese in Denver, Colorado used their own traditional healthcare before they visited the medical doctor. At least 85% of Vietnamese in the study went to a doctor only after they had already tried the traditional healthcare practices.

In another study, Yeatman et al. (1980) confirmed that 49 out of the 50 Vietnamese in the study used "coining" whenever they had headaches, back pains, or fevers, and 94% of Vietnamese in the group practiced "coining" for years even after being resettled in the United States.

In 1982, 58% of Vietnamese refugees in Seattle had used traditional health

practices, which women used much more than men (69% versus 39%); and people from rural areas used more than those who lived in urban areas (88% versus 36%) (Buchwald et al., 1982).

Dr. Le the Trung (1999) succeeded in treating superficial burning by using powder of multi-herbal medicine:

Vo cay xoan tra (bark of *Choerospondiias axillaris* Hill-Roxb *Anacardiaceae*)

La sim (Myrtle leaves of *Rhodomyrtus tomentosa* Wright-*Myrtaceae*)

Cay khao nham (*Machilus odoratis* Nees, *Lauracae*)

Cay khao vang (*Machilus bonii* H. Lee-*Lauracae*)

Huday (*Tremaangustifolia* B.I *Ultraceaa*)

Sang le (*Lagerstromia tomentosa Lythraceae*)

Su (Mangrove)

Nau (Brown tuber)

Soi (*Sti*; *lingia*)

Sen (*Illipe* Gr)

Tram (*Bassia cajeput*)

He also succeeded in researching *cay rau ma* (*Centella asiatica*) to form scars in burns, or herbal medicine of *cay sen* (*Madhuca pasquieri* Dubard H. *Sapotaceae*) and *cay lan to uyn* (*Raphidophora decursiva* - Schott- *Araceae*) against infection in burn injuries.

Dr. Cu nhan Nai (1999) stated that the powder of fresh *Rap Ca* (*Houttuynia coordata*) leaves mixed with egg white could treat ulceration of the cornea caused by *bacillus pyocyaneus*. Between 1952 and 1968 fifty-five patients were treated with this method, 40 recovered.

Dr. Hoang xuan Phach (1999) was successful in using protein extracted from tortoises to treat those who had contact with radioactive substances.

Traditional healthcare continues to affect the Vietnamese in America. Although different from Western healthcare in perception, procedure, and management, it has an important role in improving Vietnamese health conditions in America.

Vietnamese Community in Greater Springfield

In 1975, the people of the first wave of Vietnamese resettled in Springfield. Before 1989, the Vietnamese population in Springfield was small and scattered over the city. The population increased after Congress passed the Amerasian Homeland Act in 1987, allowing Amerasians and their qualifying family members to come to the U.S as immigrants (Kocher, 1993). Greater Springfield is a popular place for political detainees and Amerasians who have no relative sponsors in America, and the population has increased since 1990.

At present, there are about 5,000 Vietnamese people in Springfield and another 2,000 in other Western Massachusetts towns (Amherst, Holyoke, Hadley, and West Springfield). The population is composed of political detainees, Amerasians and their families, and immigrants. They located mostly in the Forest Park area.

The Vietnamese American Civic Association (VACA) is a nonprofit organization that works for the Vietnamese community by helping with healthcare services, counseling, interpreting, translating, and citizenship procedures (Vietnamese American Civic Association booklet, 1998). Besides the VACA, other organizations such as the Save of Sea (S.O.S) Service Center, the Buddhist temple, the Southeast Asian Apostolate,

and the Vietnamese Veteran Association also contribute to the prosperity of the Greater Springfield Vietnamese community.

Vietnamese in Greater Springfield and Acculturation

Vietnamese in Greater Springfield have overcome many problems to adjust to American culture. Like other Vietnamese who fled their country as boat people, many have been raped, starved or tortured. After resettling in Greater Springfield, they suffered discrimination by the Americans. In a study of refugees and immigrants in Western Massachusetts, Truong (2002) stated that in the Welltown Public Schools, many American students called Vietnamese students Chinese. Not only American students discriminated against Vietnamese students, even their parents did the same. They did not like Vietnamese students to have homework with their children. Even the counselor in school discriminated and obliged the Vietnamese students to learn subjects they do not like. The teacher in school considered Vietnamese students as having a minimal educational background for applying to college and suggested only community colleges. In addition, many Americans do not like Vietnamese refugees and immigrants because when they come in contact with the Vietnamese they remember their beloved dead who died in the Vietnam War.

Many factors such as education, language barriers, and low incomes influence Vietnamese acculturation. Seventy-one percent of the Vietnamese in Greater Springfield had language barriers and 39% had no transportation making access to health care very difficult (Moondoon, 1990).

In the study by Yi (1993) only 9.6% of Vietnamese women in Greater Springfield liked to speak English. When being interviewed, 86.5% liked to be interviewed in

Vietnamese language. In education, 19.1 % had high school level and 26.9% completed more than high school level. In employment, 33% hold full time jobs and 14.8% hold part time jobs. In income, 30.5% had incomes under $10,000, compared to 12.5% had incomes ranging from $30,000 to $39,999, and 8.5 % had incomes of $40,000 or over.

Health Problems

Seven of every ten Vietnamese new arrivals have a positive TB skin test and have had preventive therapy for at least six months. In 1999, the Vietnamese infected with TB were composed of two active cases, three TB class B1, and 50 in preventive therapy (Springfield Health Department, Smith Center).

In mental health, 40 Vietnamese cases were being followed up in 1999 (West Springfield Counseling Center, 1999). In 1998, 46% suffered from homesickness, 44% experienced sadness, and 3% suffered from depression (Moodoon, 1990).

In 1998, there were more than 60 adult Hepatitis B carriers and in 1999 there were six cases of pregnant woman with Hepatitis B (Springfield Health Department and Human Services, Smith Center).

Adjustment and Acculturation

Less educated women were more likely to be involved in Vietnamese community activities than those who have higher levels of education. People who have been affiliated with religions such as Catholics or Buddhists, are more acculturated than those who are not. Single women used English more than the married women. Women with high school levels of education spoke English more than those who were less educated. Women with one or more children used English less than those who had no children (Yi, 1993).

Many of the parents, 75.7% (25/33), would like their children to maintain their

own language, and did like American culture because it has too much freedom, which allows too much intimacy between the sexes and leads to the loss of the relationship between the parents and their children (Truong, 2001).

Women who were more acculturated are likely to have more mammograms, breast examinations, and/or Pap smear examinations than those who had less acculturated. Married women were likely to have less embarrassing when screening breast examination than those who never married (80% versus 46%). Among the Vietnamese in Western Massachusetts, ages 50-65, only 58% have had a pap screening and breast examination. Women with no children had fewer breast examinations (36.5%) than women with one or more children (67.6%) (Yi, 1992).

In treatment, only 20% of the Vietnamese went to visit the doctor, 18% had dental care, 35.5% felt better after treatment, and 42% were worse (Mondoon, 1990). Twenty-four percent of households said that one in their household did not receive health treatment, and 50% claimed they had the same problem after treatment (Yi, 1993).

In short, Vietnamese in Greater Springfield have to overcome many problems to adjust to American culture. They adjust or acculturate to the American healthcare more or less depending on many factors, such as income, language, and level of education.

CHAPTER III

METHODOLOGY

Research Design

This chapter describes the research design, sampling, and data collection, data analysis methods of the study. An exploratory study based on qualitative methods is used in this study, to explore problems in-depth while understanding the situation in context (Strauss & Cobin, 1988). Most previous research studying Vietnamese healthcare in Western Massachusetts, including the city of Springfield, has been quantitative. Although these studies examined health behaviors of Vietnamese in the American system, they did not investigate the different reasons behind the use of American healthcare and traditional healthcare, or how two different paradigms of health can influence in each other. They focused only on American healthcare for Vietnamese in general, and failed to offer an in-depth explanation. Therefore, an in-depth qualitative research methodology was appropriate to gain greater insight into the problems. As Seidman (1991) confirmed, "at the root of in-depth interviews lies an interest in understanding the experience of other people and the meaning they make of that experience" (p.3).

Sample

To understand how culture influences healthcare for Vietnamese, I selected a sample of 14 Vietnamese adults and elderly of the Greater Springfield area who were of different ages (30 to 67), sexes, educational backgrounds, incomes, and duration of time living in America. Some are detainees and others are Amerasians. More importantly, in

the sample, I also selected some healthcare workers working with Vietnamese people in Western healthcare. Their services in the Vietnamese community, as well as their bilingual and bicultural background, play an important role in Vietnamese healthcare access. By the diversity of the sample, we can understand more deeply the Vietnamese's involvement in the American healthcare system. Table 1 summarizes the demographic characteristics of the sample.

Table 1. Demographics of the Sample.

Age		
	30-44	7
	45-59	4
	60-75	3
Sex		
	Male	7
	Female	7
Education		
	Elementary School	3
	Junior / High School	6
	College	5
Immigrated to America		
	Before 1992	5
	After 1992	9
Income		
	Under $20,000	3
	$20,000-$39,000	8
	$40,000 and over	3
Career		
	Health worker	3
	Factory worker	4
	High School teacher	1
	Tailor	1
	SSI (Social Security Income)	1
	Welfare recipient	1
	Dietary worker	1
	Truck driver	1
	Cosmetics	1
Location		
	Amherst	2
	Holyoke	1
	Springfield	11

Data Collection

In-depth Interview

The ethnological interviews were open-ended, dialogic, and face-to-face, allowing for flexibility and an in-depth exploration of the topics. There were 35 open-ended, follow-up questions related to health utilization, beliefs, behaviors, practices, and education, for both American healthcare and traditional healthcare (Appendix A). In the interviews, I drew on and reinforced the respondents' experiences and was sensitive to the feedback and concerns of the respondents. One respondent, a welfare recipient, was scared about my study, and thought that if she expressed her ideas differently from the established health policy she would lose her welfare benefits (this is part of Vietnamese culture: the inferior does not dare to criticize the superior). In this case, I explained that her opinions did not influence her welfare benefits but helped authorities find the best way to resolve problems. I also encouraged respondents to make some suggestions for healthcare, even though they thought the Vietnamese population in Greater Springfield was a small ethnic group compared to the Hispanic and Russian groups.

The interviews were held in the respondents' homes. The amount of time was one hour and a half. The interviews were held between March 26 and September 25, 2002. The interviews were tape-recorded, and I interviewed all the respondents in Vietnamese (the researcher speaks the same language as the interviewees. In entering the data, I translated it into English). Before the interviews, I contacted the respondents at their homes or telephoned them. After I explained the purpose of the study and they agreed to be interviewed, I set up a schedule for the interview, often one week later, to give them time to think more about the issue. All participants signed a consent form (Appendix B)

To begin the interview, I asked for their permission to tape record the whole interview, explaining it would help me remember what they had said. I also let them know that I would listen to the tape many times to understand more of what they said. I had conversations with them, not taking notes, to save time.

Participatory Observations

I used participatory observation to go inside the problem and discover the complexity of the problem. During home visits, I discovered that some participants who are welfare recipients, beside their benefits from SSI or welfare, work under the table in jobs at farms or in factories, to increase their income in response to their increasing needs.

I also made observation field trips to Saigon market and Dong Nai Asian market in Springfield, which provide fresh and dried medicinal plants, herbal grasses, and other supplies used in traditional healthcare practices. Even CVS and Wal-Mart stores have many traditional and herbal medicines for sale. I also collected observations in a clinic (in the waiting room and physician's examination room) where I observed the doctor's behavior, the client's feelings, and their reactions to each other. As an interpreter at the clinic, I have many opportunities to interpret and observe the doctor's behavior with the client and the client's reaction to the doctor. Many times, after examination, while waiting for the doctor's evaluation in the examination room, I have time to talk with the clients, and to know their feelings about the examination.

As part of working with the Vietnamese in healthcare, I always make home visits and follow up TB active cases and preventive-active cases. By this contact I know what they think about preventive therapy and their reaction to treatment. I also conducted

participatory observation of healthcare activities in the community, such as Monthly Health Research Day (Health Prevention Day) of the Vietnamese American Civic Association (once a month), health fairs in the community, and monthly Vietnamese Community Health Task Forces meetings, to understand much more. I took notes during these observations. (See sample in Appendix C.)

Data Analysis

I organized and systematized data in response to the study. I transcribed all taped recorded interviews into written form, analyzed and organized the raw data (transcripts, field notes, and tape-recorded interviews) in their own words. I read and listened repeatedly to the field notes and tape-recorded interviews, and then entered the data into computer software. The data is organized into themes and topics related to the study. With direct quotations, the respondents provided me with their perceptions, beliefs, and practices, which reflected their thinking. Once more I read and reread data many times to be familiarized, and to immerse myself, to stimulate analytical thinking and sort out the data into categories. I reorganized the data into salient themes responding to my research questions.

I used coding as a means to "clear about what words or phrases illustrate and elaborate each of those concepts" (Rossman, 1998, p.180). When I immersed myself in the collected data, I tried to sort out the details and connect data from each interview into themes, the similarities and differences, and to their opinions about what the questions suggested. I tried to understand the inner feelings of the participants, their situation in

life, and what meanings they wanted to express. Then I "recoded the data, refining those categories or adding new ones" (Rossman, 1998, p.180).

I tried once more to clarify and purify the data by combining what I had observed and extracted from the interviews in triangulation, so that the data became more precise and valuable. I also tried to find out what was similar as well as what was different between the interview data and participant observation data. Many times the respondents, for whatever reasons, did not dare to respond honestly, perhaps because of fear of loss of their benefits. Therefore, I tried to combine and compare their actions to their words, to find out the most reliable data, reflecting their true life. Then I outlined the findings. Generally, from the dialectical conversations with the respondents, the realities of their social integrations were transcribed and organized into themes and categories. .

Validity and Reliability

The data collection's validity is strengthened because I am an insider in the community, and have worked as a community health worker for ten years, since 1993. I have interacted with the respondents many times, and have their confidence. Before interviewing, I contacted them and offered them a period of time (at least one week) to think about the issue. These data are also valid because I applied the triangulation method to check and confirm by using more than one method. I combined participatory observation, case study, and the interviews to determine the results of the study. To keep confidentiality for the interviewees, I used pseudonyms whenever I quoted their statements, ideas, feeling, or proposals.

Limitations

In the process of data collection, it is likely that some problems limited both the accuracy and completeness of information gathered. There were three respondents with M. Ed., one with a B.A, while the remainder were educated to either the high school or elementary school level. Because some of them are SSI or welfare recipients, they may not have been open with the interviewer, or may have been afraid of losing welfare assistance as a result of expressing what they need.

The information I could get from a sample of 14 respondents has limitations. Maybe it represents a large number of Vietnamese in Greater Springfield, but not all. Therefore its benefits and accuracy are limited and need more study to accurately reflect the healthcare access of Vietnamese adults and elderly.

CHAPTER IV

RESULTS AND ANALYSIS

This chapter presents the data analysis from the 14 interviews. The data analysis is separated into five sections, based on the research questions. The first session reviews biographical background of the respondents. The second section contains an overview of the respondents who used healthcare in Vietnam before entering the United States and their access to both American and traditional healthcare in America. The third section addresses problems Vietnamese encounter when they become involved in the American healthcare system. The fourth section hypothesizes how American and traditional healthcare can be integrated for the betterment of the Vietnamese residents of Greater Springfield. The final section addresses the importance of health education in improving healthcare for Vietnamese in Greater Springfield, as well as other regions of high Vietnamese concentration in the United States.

The theory of acculturation indicates that acculturation is influenced by age, sex, education, income, and length of time in a new country. This theory will be used to explore whether or not these factors play an important role for Vietnamese in accessing healthcare.

Kleinman (1978 a) states that both traditional and American healthcare systems can exist and support each other. This study help to determine if two healthcare systems can possibly co-exist, even with different structures, and how this can happen so as to enable Vietnamese to achieve good healthcare. I would like to emphasize that the concepts of traditional healthcare of the respondents in this study are reflective of their

culture. They may not be appropriate, or may even sometimes be contradictory to health science, which is based on experiments and research.

Respondents' Biographical Background

Some biographical descriptions of 14 respondents are necessary to understand the influence of culture toward healthcare access. They are grouped in three categories depending on educational background: elementary school level, junior and high school level, and college level.

Elementary School Level

Chau Binh is 65 years old. She came to America as an immigrant in the Amerasian Homeland Program in 1989. She has a large family with eleven children. She gets SSI, and is at home to take care of her grandchildren.

Huong Le is 39 years old. She came to U.S.A. with her son to reunite with her family in 1994. She finished elementary school in Vietnam and works as a cosmetician.

Lan Nguyen is 39 years old. She left Vietnam in 1990 and lived in a refugee camp in Thailand for more than seven years. After the camp closed, she had to return to Vietnam. In 1998, she came to America with her entire family. At present, she takes care of her children and receives welfare benefits.

Junior and High School Level

Anh Nguyen is 53 years old. He is a Vietnamese veteran. He has lived in America since 1996. He speaks English fluently and works for a company as a factory instructor. He participates in many activities in the Springfield community.

Hoai Dinh is 33 years old. He moved to Springfield from Chicago in 2001. He has lived in America for more than nine years. He works in a factory as a technician. His family lives in Chicago.

Linh Pham is 52 years old. He came to America with his son in 1990 as boat people, after living in a refugee camp for many years. He finished junior high school in Vietnam. He reunited his family in America in 2000. He is now a factory worker.

Minh Le is 38 years old. He resettled in America in 1998 as an immigrant. He works for the Milton Bradley Company as a machine operator.

Ngoc Dung is 41 years old. She came to America in 1989 as a boat person after a period of time in the refugee camp. She worked for the Vietnamese Health Project in Springfield to provide health services for Amerasians and their families. After this program was closed in 1994, she was transferred Mercy Hospital. Now she is a health coordinator for the Vietnamese Health Project at Mercy hospital providing health services for the Vietnamese in the Greater Springfield area.

Tuan Khanh is 30 years old. She came to America in 1993 in the Amerasian Homeland Program. She finished high school in Vietnam and is applying to the early childhood program at Springfield Community College. She is a manager for a tailor shop in the Greater Springfield area.

College Level

Bien Tran is 66 years old. He has been resettled in America since 1993. He was a Lieutenant Colonel in the South Vietnamese army. He was in a concentration camp after the Vietnam War for more than eight years. Bien Tran was a healthcare case manager for long time in the Vietnamese community in the Greater Springfield area. Now he works as

a health worker for the Springfield Health Department and Human Services. In America, He continues to complete his education. He graduated with a Bachelor's degree in 2000 and a Master of Education in 2002.

Chau Toan is 52 years old. He came to America in 1991. Like other officers in the South Vietnam army, he was in concentration camps for more than five years. In America, he continues to complete his unfinished education in Vietnam. He graduated from Greenfield Community College with an Associates Degree and continues to study at the college. He works as a truck driver for the University of Massachusetts.

Hoa Nguyen is 67 years old. He left Vietnam for the United States in 1992 with his family. Previously he was an officer in the South Vietnamese army and a teacher in a public school. He was in a concentration camp for more than six years. In 2002, he completed his education at the University of Massachusetts (Amherst) with a Bachelor's degree. He has just received a Master of Education in 2004. He currently works as a dietary worker.

Hoang Nien is 46 years old. She came to America in 1992 as an immigrant. She received a Bachelor's degree in Vietnam and was a high school teacher. In 1972, she went to the Philippines to continue her education. In America she is a teacher in a high school and an interpreter at Bay State Medical Health Center. She received a Master of Education from Cambridge College in 2000.

Xuan Vo is 34 years old. She has lived in America since 1990. She had some college background in Vietnam. She worked at The United States Catholic Conference (USCC) for Vietnamese new arrivals. After the USCC closed she worked at the Southwest Health Center as an interpreter.

Overview of Healthcare Access in Vietnam Before 1995

This study reflects the healthcare system of South Vietnam before 1995, when most respondents of the interviews had lived in South Vietnam. In 1954, the Geneva Agreement divided Vietnam into two states, North Vietnam and South Vietnam. It is likely that there could be slight differences in healthcare between the South and the North. North Vietnam was a Communist regime while the South was Capitalist for more than 20 years before they became united, in 1975, at the end of Vietnam War. Although the Communists have been in control of South Vietnam since 1975, they have not brought many changes to the health structure of the region. However, in 1995, Vietnam opened its doors to capital investors in order to improve its own economy. Since this period, Vietnamese have more contacts with foreigners and foreign companies and organizations. It is likely that these outsiders have had an influence on Vietnamese healthcare activities.

Vietnam is crucial in Southeast Asia because of its location. Surrounded by China, Singapore, Indonesia, and Malaya, with a 3,200-kilometer ocean borderline, Vietnam is an important transportation route for Asian and European countries. Thus, through its numerous contacts, Vietnam has been influenced by many outside cultures. The Chinese had ruled the region of Vietnam for over 1,000 years; in the late 19th century, it was invaded by the French, and hence became a colony of France. China and France both occupied Vietnam, and exported their cultures to the Vietnamese. As a result, the healthcare system existing in Vietnam, beside its native southern healthcare, consists of two more: Northern healthcare (Chinese) and Western healthcare systems (European).

Vietnamese can practice Western healthcare but at the same time remain rooted in their traditional practices. The different healthcare systems in Vietnam are not conflicting, but rather mutually supportive to enhance health conditions for the Vietnamese. People in the rural areas have less access to Western healthcare, due to transportation and medical care's high costs. They practice more traditional healthcare, using more natural medicines than do those in the urban areas, because their environment allows them to grow and obtain herbal and natural medicine plants.

Since 1975, to promote self-sufficiency, the communist regime encouraged all peoples of urban and rural areas to use traditional medicine. Like Hanoi, the capital of Vietnam, Vietnamese authorities have established the Traditional Medical Research Center in Saigon (Ho Chi Minh City) to improve traditional healthcare for the South Vietnamese. Due to this movement, Vietnamese people have become involved in traditional healthcare more than ever.

Western Healthcare in Vietnam

From its beginnings under French colonization in the 19th century, Western healthcare in Vietnam has played an important role in improving healthcare for Vietnamese people. Western healthcare has existed in Vietnam for a long time. During the 17th century, many Western missionaries (French, Spanish, and Portuguese) came to Vietnam to evangelize, and at the same time, they brought Western healthcare with them. They established a hospital in Hue, in Central Vietnam. In 1747, one physician named Duff cured an anal fistula for the Lord Vo Vuong. When Gialong of the Nguyen Royal Dynasty had good relations with and received support from France in taking back the throne in the 19th century, many Western physicians came to Vietnam. J.M. Despiau was

Gialong's primary doctor and the Court's. Later on, because of increasing tensions between France and Vietnam, physicians avoided coming to Vietnam, until the time when France started to occupy Vietnam as one of its colonies (Hoang et al., 1999).

In general, Western healthcare in Vietnam had the same philosophy, methodology, and chemotherapy as that of Western countries; however, if compared to the American healthcare system, it differs in strategies used, management, and illness prevention.

Healthcare Strategy and Illness Prevention

The Western healthcare system in Vietnam has no primary doctor or family doctor policy. Doctors have no responsibility to follow up on their clients. Many times, in response to the client's needs, the Vietnamese doctor works as both a general doctor and a specialist, even if he is not specialized. For instance, he treats stomachaches even when he is not a stomach specialist. Except for a small number of doctors working in clinics or public hospitals, many have their own offices (including doctors in hospitals who work another job outside the hospital), and work individually to provide healthcare for the Vietnamese. They are called private doctors. Because hospitals are only located in the city, and admission to them is complicated, Vietnamese rarely go to the hospital or clinic if not seriously ill; they go to private doctors or specialists. Because the country is underdeveloped, Vietnam does not have enough specialized doctors for its nearly 80 million people. Most specialists are concentrated in Saigon, Hanoi, and several of the provinces. As a result of not having their own primary doctor, Vietnamese people are not familiar with regular examinations. Vietnamese think that visiting the doctor regularly is not necessary, particularly if they have no symptoms of disease or other health problems.

Depending on whether their condition improves or not, Vietnamese can change doctors as much as they like without interference from any insurance company, as happens in the United States. If health problems need to be treated by a specialist, the patient does not require a referral from a private doctor.

Before 1995 Vietnamese have not been accustomed to health prevention. Health prevention is not a priority to Vietnamese healthcare. As an underdeveloped country, enduring war and self-sufficiency for more than a quarter-century (1945-1975), Vietnam has no effective plans for health prevention. The Vietnamese are not encouraged to use prevention programs, especially programs about communicable diseases. Even children, especially easily infected newborn children, are not protected enough against diseases. Vietnamese doctors do not encourage clients to get breast exams, Pap smears, or prostate screenings annually, although every year nearly half million women die of breast cancer in underdeveloped countries (Thien Y, 2003).

Vietnam is a high-risk country for Tuberculosis and Hepatitis B. The rate of Tuberculosis infection reaches 44% of the population (VNN, 2003), but the government has no effective policy to prevent it. In response to the interviewer's question about Western healthcare in Vietnam, Thuy Huong recalled.

> We never hear about vaccination for adults. We never have any Hepatitis B shot, despite my country being at high risk of Hepatitis B. We do not have annual breast, mammogram, or cervix cancer examinations.

Along the same lines, Thuy Huong and Anh Nguyen talked about healthcare services missing in Vietnam:

> Our country is at a high risk of tuberculosis (TB); we do not have skin tests. Some people have BCG (Bacillus Calmette Guerin), but only for some individuals, not for all people.

Vietnam does not have a health insurance system as well. The government has no policy regarding health insurance. Due to financial limits, the government only partly covers healthcare for people in public hospitals, and requires patient co-payment. Companies have no health insurance policies for their employees. Nobody has health insurance, or is familiar with the health insurance system. When visiting the doctor, the client must pay all the costs.

Health Management

In contrast to the American healthcare system, visiting the doctor in Vietnam does not require an appointment; the client can go to the doctor's office anytime, where its doors are always open to welcome any client. According to Hoang Nien:

> In Vietnam, visiting the doctor does not require an appointment. The doctor's office is open from 8 A.M to 7 P.M, even on Saturday and Sunday, and welcomes everybody. When we come to the doctor, we take a ticket and wait in the waiting room. The doctor examines the patient only briefly. In the waiting room, if someone is in serious condition, he could ask anyone waiting to give him priority to see the doctor.

Laboratory work, such as blood tests, urine tests, sputum tests, biopsies, or X-ray films is the best way to be precise in diagnosis and in choosing effective treatment. Except in a clinic or hospital, Vietnamese doctors in their primary office are less likely to depend on such procedures. A doctor examines the clients based on their symptoms and feelings, not on laboratory work that is expensive and complicated. Vietnamese private doctors also do not set up medical records to follow up on patients.

In treatment, a Vietnamese doctor places much more emphasis on medicine than on physical therapy, an individual's immune system, or diet, to fight against the disease. Based on the Vietnamese belief that to go to the doctor without receiving any medicine is to be cheated (Muecke, 1983 b), for general symptoms (coughs, fevers, and headache

symptoms), Vietnamese doctors often gives prescriptions to the clients, including some antibiotics, even though they do not have bacterial infections. Vietnamese doctors are also acquainted with the idea of giving shots (often of vitamin B or C) to clients in any visit. They want to satisfy the many Vietnamese who believe that injecting a drug into the body is necessary to get better. Hoang Nien stated:

> Based on the effectiveness of antibiotics, which can quickly relieve fever and coughs, a Vietnamese private doctor is likely to treat his clients according to the client's wish rather than based on medical therapy. On every visit for common diseases, the doctor gives his clients medicine, accompanied with antibiotics. Vietnamese doctor does not need to know the consequences of antibiotic resistance.

To have more clarification about Vietnamese health care, Lan Nguyen confirmed:

> Many private doctors give their clients a shot (generally of vitamin C) and some vitamin medicines, although such a shot and medicines do not treat the disease exactly.
>
> Even in America, Vietnamese adults and elderly like to visit the doctor who has the same examination methods as they had in Vietnam. For example, in Springfield, a Vietnamese doctor on Main Street continues to give the same diagnoses and treatments for his clients as in Vietnam. Whenever examining Vietnamese, he has a shot and some medicines ready for them, and his clients are very satisfied.

In Vietnam, there is no clearly distinguished role between the doctor and the pharmacy. Doctors can sell medicine to their patients, instead of giving a prescription for ordering medicine at a pharmacy. Hoang Nien would like to compare healthcare in South Vietnam before 1975 because it was controlled by the Communists after 1975:

> Before 1975, whenever I went to the doctor, he would give me a prescription to order medicine at the pharmacy. But since 1975, after the Communists took over South Vietnam, every time I went to the doctor, he would sell me the medicine instead of writing a prescription. I had a feeling that the doctor's office is like a grocery store.

Pharmacies in Vietnam do not require a doctor's prescription; anyone can order medicine, even antibiotics, without a prescription. Anyone can buy medicine in the drug store, or at the flea market. Chau Binh stated the reasons why she did not visit the doctor very many times:

> After the diagnosis, the doctor sold me some medicines. I kept those medicine labels for next time. If I had the same symptoms, I would order them from pharmacy, because pharmacy in Vietnam did not require any prescription from the doctor. I did not need to visit the doctor again.

Vietnamese doctors, when giving prescriptions, do not depend on the patient's weight, but only on his prediction. This is why Vietnamese adults and elderly adjust their medicine when accessing healthcare. They always think that Vietnamese people are thinner and shorter than Americans.

Because visiting the doctor and ordering medicine are expensive, Vietnamese turn to self-treatment and self-sufficiency. Many Vietnamese want to save money by not following the doctor's regimen exactly. They often take medicine until the symptoms disappear and then stop, to save the medicine for the next time. Chau Binh explained:

> The doctor gave me a two-week medicine regimen. I took it for only one week and my symptoms disappeared. I stopped and kept the remaining medicine for next time, in case my relatives or I have the same symptoms

In short, although based on Western health theory, Western healthcare in Vietnam is different from the American healthcare system. Whenever leaving their country to go to another, Vietnamese cannot easily erase the memories from their lives.

Traditional Healthcare

Traditional healthcare has an important role in improving healthcare for the Vietnamese. Although Western healthcare influences the Vietnamese, traditional

healthcare has been combined with the northern healthcare (Chinese healthcare) and Western healthcare. Traditional healthcare is based on the "Hot" and "Cold" theory, in which a human being is perceived as a unit in the universe. Disease comes from the imbalance of "Hot" and "Cold ". By such a concept, traditional healthcare uses nature as the means for healing.

The most common ways that Vietnamese fight against illnesses is to use the ancient, traditional healthcare practices of coining, cupping, spooning, and herbal steaming. When having symptoms such as headache, fever, or coughing, Vietnamese like to use the traditional health practices to treat the symptoms. These traditional health practices are popular from the city to rural areas.

Together with traditional healthcare practices, Vietnamese also go to Vietnamese southern practitioners (traditional health practitioners) for health treatment. In every ward, district, city, province, and in the capital of Vietnam, Vietnamese southern practitioners set up offices to diagnose and deliver herbal medicines to their patients. Generally, Vietnamese southern practitioners, who were trained by their masters or gained experiences from predecessors, diagnose and use southern medicine combined with northern medicine to treat their clients. Patients using traditional medicine often go to southern doctors in their communities, or in nearby areas. The client and the practitioner may know each other, as well as have a good mutual relationship.

The traditional southern health practitioner's diagnosis depends on the patient's feelings and symptoms, concentrating on the balance of "Hot" and "Cold". He focuses on the cause of illness rather than on a simple symptom, and gives the patient the treatment, which makes the body self-correct. If the client has too much "Cold" the practitioners

will give him "Hot" medicine. If the clients are "Hot," the southern doctor will give them the "Cold."

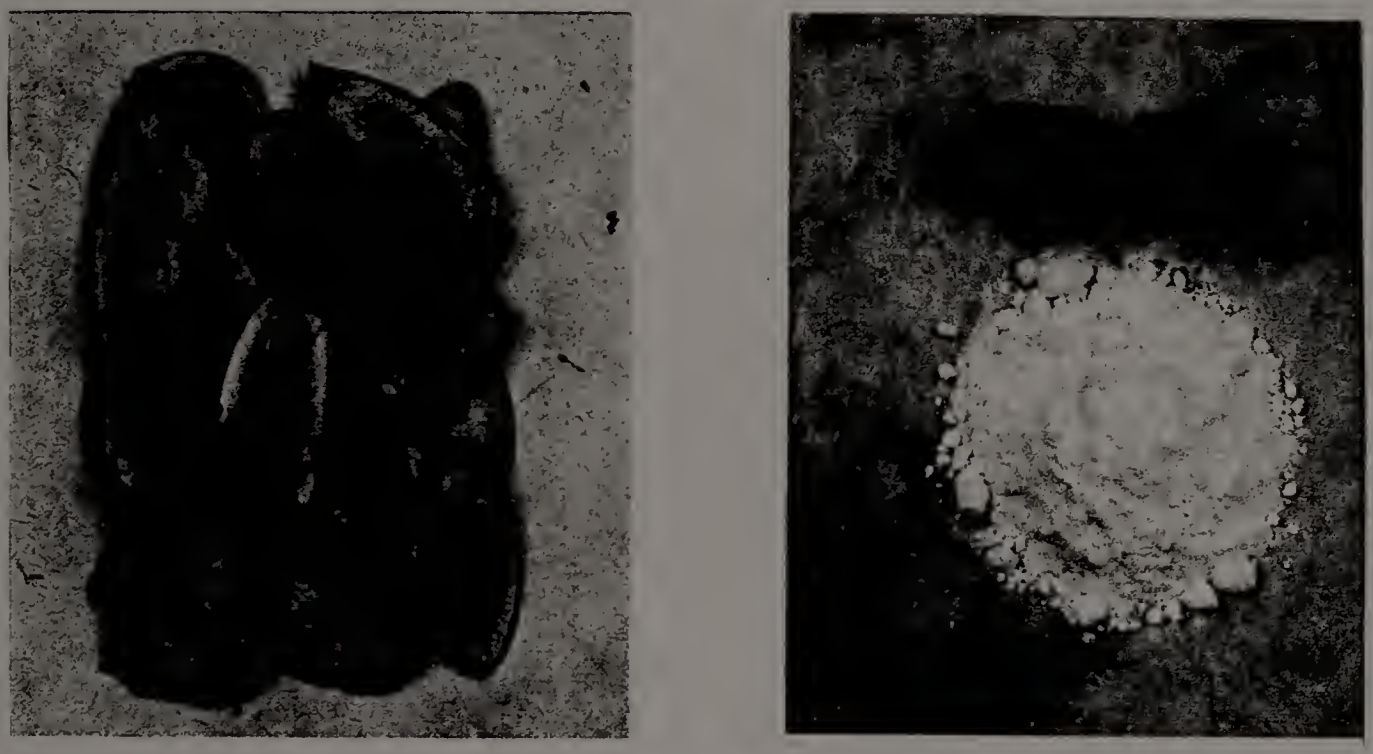
In addition to the southern healthcare, many Chinese Vietnamese health practitioners provide northern healthcare for their clients. Their offices often are located in the cities, or provinces, especially in Cholon province, next to Saigon, in South Vietnam. Southern medicine often requires a long regimen; the southern practitioner often gives the client a two-week regimen, or longer if needed. The patient needs ten or twenty days to recover.

Both southern and northern health practitioners use powder, liquid or pill forms of medicine in addition to using grasses or other plants, often dried, that grow in Vietnam or in China, which are boiled until a small amount of medicine water is acquired (two or three cups) (Figure 1).

Herbal Medicine for Self-Treatment

Besides going to the southern health provider, Vietnamese also know how to use fresh herbs and plants as medicines. Herbal medicines are popular in Vietnamese healthcare. Being in a tropical area, Vietnam has many medicinal herbs and plants to treat diseases. Medicinal plants and grasses are everywhere in Vietnam. They can grow in the wilderness, along riversides, along the roads, or around houses. The Vietnamese know how to use them as medicine. By tradition, they like to use natural medicine for self-treatment. They know the effectiveness of natural medicine from their own experiences and those of their ancestors, which are passed down orally from generation to generation. Many kinds of herbs, fruit trees, vegetables, seeds, and even flowers are used for eating and for making medicine. (Figure 2)

Figure 1. Traditional Medicine



Source: Underwood (2003)

Figure 2. Examples of Medicinal Plants

Ginger (Gung)
Source: Vu dinh Trac (1987)

Pueriria Thomsonii (San giay)
Source: Nguyen van Dan (1999)

Perilla (Tia to, tu to)
Source: Nguyen van Dan (1999)

Animal Medicines

Vietnamese people also use certain living or dried insects, reptiles such as lizards, toads, serpents, or wild animals that live in the great forest such as bears and tigers for medicine. An animal for medicine can be used whole if small, like serpents or toads, or in parts (skin, bones) if they are big ones such as bear and tiger. The honeybee is good both nutritionally and as medicine. It treats gastric pain and dry cough. *Cao ho cot* (tiger bone jelly) is a good traditional medicine. The antler shoots of deer can be used to strengthen one's health. Many Vietnamese parents are likely feed their children rice soup mixed with fresh deer horn powder, especially if they are thin because southern health providers often recommend eating fresh deer powder for weight gain. Bear's gall is used to treat muscular pains, indigestion, jaundice, poisoning, and other ailments. Only a tiny amount of bear gall mixed in alcohol is enough to stop swelling in any part of the body. Anh Nguyen explained the benefits of bear's gall:

> Bear's gall is a precious medicine. It is effective for treating muscular pain, especially pain and swelling caused by accidents such as falling down a ladder, tree or the roof of a house. Only a tiny amount of bear gall mixed in alcohol is enough to stop swelling.

In addition to Anh Nguyen's explanation, Tuan Khanh said:

> My mother likes the bear gall because it is very effective to treat pain. Medicine will be better when the gall is taken from the bear, which eats fruits on the tree, becomes drunk, and falls down.

Snake's gall is also a good drug in traditional medicine; it treats rheumatic pain and burns. A snake's flesh is highly valued. Soaked in alcohol and herb medicine for a couple of months, it becomes good for health improvement, especially if one suffers from rheumatic pain (Nguyen xuan Thu, 1999). Lan Nguyen recalled the effectiveness of traditional medicine:

Figure 3. Examples of Medicines of Animal Origin

Reptiles

Spider

Mammals

Monkey

Snake

Tiger

Source: Hutchins et al. (2003)

> In Vietnam, my father always takes a cup of snake alcohol before lunch or dinner everyday. It helps keep him strong against diseases. As a result of this practice, although 65 years old, he looks like a young man .

Besides tiger bone, bear gall, and honeybee, Vietnamese also use many animals for medicine such as caterpillar for children with convulsions, crickets for diuretic, and spiders for nocturnal enuresis, and cock's gall for whooping cough. Even the human placenta is used as a tonic medicine; powdered placenta can treat broncho-pulmonary ailments and rheumatism. Many Vietnamese drink fresh urine from a boy under 12 years old to treat headaches (Nguyen Xuan Thu, 1999) (Figure 3).

In general, Vietnamese use traditional healthcare to treat their health problems in many different ways. Each treatment depends on their traditional health practices, natural herbs and plants, and animal medicines. Beside Western healthcare, imported in the 19th century, Vietnamese would like to treat illness based on their traditional healthcare, which is appropriate with their culture and their environment.

Vietnamese Adults and Elderly in Greater Springfield Participating in American Healthcare

Leaving Vietnam for the United States because of political discrimination, many Vietnamese are likely to be unhappy, despite having better living conditions here than in their home country. Vietnamese culture, which has existed for four thousand years, always reminds them of their ancestral land. In general, many newcomers to this country feel uncomfortable in a new culture. Many of them are homesick, or even suffer mentally, because they cannot adjust easily to a country where the customs, food, and tradition differ so much from their own.

Vietnamese healthcare is different from the American model in concept, strategy,

management, and healing activities. To survive in the new land, Vietnamese refugees and immigrants must struggle to keep what cannot be replaced from their culture, and fight against whatever is preventing their adjustment in the new society.

The health status of Vietnamese in Greater Springfield is likely to be fairly poor. In the sample, among 14 respondents, only 9 are healthy (64.2%), 1 (7.1%) has stomachache, 1 (7.1%) has arthritis, 2 (14.2%) have eye problems, and 1 (7.1%) has diabetes and high blood pressure. Vietnamese in Springfield need more healthcare services than ever.

Living in the United States, no matter whether they like it or not, Vietnamese must be involved in the American healthcare system to survive. Many studies state that there is a relationship between age, sex, education, income, profession, marital status, language and access to healthcare. The more educated the immigrants are, the more they will participate in the host healthcare. The more English they speak the more likely they will be to have healthcare access. Do cultural components such as age, education, income, and time in America influence Vietnamese healthcare?

Vietnamese and American Healthcare

Although having a different culture from Americans, Vietnamese adults and elderly in Greater Springfield are not surprised at the American healthcare system; on the contrary, they have a good understanding of it. When asked for their feelings about American healthcare, most respondents asserted that the system is very good (some said excellent) at improving the condition of their health. Highly technological American healthcare can treat many fatal diseases such as HIV (Human Immunodeficiency Virus) and cancer. Linh Pham is surprised and impressed at hearing and reading about

successful operations such as organ transplants, or kidney stone removals, which are performed with the goal of lengthening the lifespan of humans. He said:

> The American healthcare system is modern and scientific. We are lucky to live in this country where healthcare is one of the top issues that concerns Americans. However, it is unlikely that American healthcare can treat all diseases, but it is the best compared to other countries' systems all over the world.

The American healthcare system is excellent because it is specialized. Specialization is very necessary to help the specialists become more involved in and advance their careers. In addition, the government encourages people to invest and do research in healthcare. Many studies have been conducted to improve healthcare for Americans. According to Hoa Nguyen:

> The American healthcare system is one of the most effective in the world, not only in general healthcare but also in specialization. Doctors only focus on their specialized area, and try to strengthen their careers. Thus, American healthcare advances forward unceasingly. Many new medicines and treatment techniques have been discovered to improve health conditions for Americans.

Chau Binh, a member of an Amerasian family, had a feeling when accessing healthcare in the United States:

> In Vietnam, I lived in a rural area. I rarely went to the doctor's. I only used traditional healthcare. Going to the doctor for examination is too expensive. You know, I have 11 children. Every day, I worked hard to get money to buy food for my family. I did not have enough to pay the doctor.
>
> I came to the United States by the Amerasian Homecoming program; I get the assistance from the government: food stamps and medicines. I am old, and I have diabetes and high blood pressure. I get Medicaid. Every day, a nurse comes to my house to inject insulin and give me medicines. I cannot speak English. Whenever I go to the doctor's, a Vietnamese translates for me. Thank you, America, for your support.

However, American healthcare also has many problems: One of the problems is that it is a complicated system, which is composed of many sectors, such as managed care, Medicare, Medicaid, health insurance, primary doctors, and specialists. Hoang Nien said:

> The American healthcare system is very good but rather complicated. How do I respond to this system that requires a lot of work: laboratory (urine, blood tests), the insurance company, and managed care.

In short, Vietnamese adults and elderly in Greater Springfield have accurate perceptions of American healthcare. These perceptions do not appear to be related to age, sex, education, income, or period of time in America. However, in healthcare access, many Vietnamese still feel that American healthcare is not as simple as their Western healthcare in Vietnam.

Primary Care Doctor

The primary, or family doctor concept is central to the American healthcare system: it is the point at which any healthcare access must originate. Everyone must have a primary doctor. The primary doctor has the responsibility to take care of and follow up on the health of individuals and families. He is the decision-maker for his patients. First of all, if experiencing any symptoms or health problems, the patient must go to the primary doctor to be diagnosed, and he must treat any illnesses. If the doctor finds out that the client has a serious health condition that surpasses his ability to diagnose, he will refer the client to a specialist, or to a clinic or hospital. The hospital or specialists, based on the client's medical record and the recommendation of the primary doctor, will continue to treat and follow up on the patient.

Although originally from Vietnam, where the healthcare system has no primary doctor policy, Vietnamese in Greater Springfield do not reject this system. Through support from the government or the companies they work for, most Vietnamese in this area have primary or family doctors.

All 14 respondents have health insurance (100.0%). Besides people getting health insurance coverage through their jobs, most Vietnamese in Greater Springfield are more

eligible to get Medicare, Medicaid, and Mass Health than any other ethnic groups, because all of them are legal residents. Any legal resident living in Massachusetts who is over 65 years of age, has a qualifying low income, or is unemployed, gets insurance coverage from the state (Mass Health). With health insurance coverage, Vietnamese can choose a primary doctor or family doctor more easily.

Vietnamese adults and elderly of Greater Springfield recognize the need to have a primary doctor to follow up on their health condition. Hoai Dinh mentioned:

> The primary doctor policy is very good. If I don't have a primary doctor, who will take care of my health? We appreciate this system because it enables anybody to have a primary doctor.

Many Vietnamese adults and elderly must choose their primary doctor based on managed care. In particular, those who get Medicare, Medicaid, or Mass Health must belong to managed care. Their health benefits coverage are then limited within its guidelines.

In general, the acculturation of Vietnamese in America is recognized in the choice of a doctor. Based on the experiences of the 14 respondents, who have a primary doctor, Vietnamese are likely adjust to the new culture. This adjustment is experienced by people of either sex and of different incomes, education levels, and periods of time spent in America.

Doctor Visits

Frequency of doctor visits is one way to know whether or not Vietnamese people are involved in the American healthcare system. To avoid contracting diseases, and to maintain or improve general health, it is necessary for everyone to eat balanced meals, exercise regularly, and visit the doctor once a year for check-ups (Spector, 1996). Americans often go to their primary doctor at least once a year, twice a year for those over 60 years old. Regular examinations are very important, to detect any diseases in the

preliminary stages. Treatment is easier and more effective if the health problems are found early. Many diseases, such as cancer, can be treated with relative ease if found at the beginning stage of development.

As for annual check ups or examinations in Vietnam, Vietnamese rarely go to the doctor for check-ups annually; they only go when they have symptoms or serious health conditions.

Although 14 (100%) of the respondents have primary doctors and health insurance, it does not follow that all of them have regular examinations; only 7 (50.0%) reported having an annual examination. The use of regular examinations also depends on age, sex, and amount of time in America. The elderly (100%) are more involved in annual examinations than the middle aged (50%) or the young (28.5%). Those who live longer in America (60.0%) more often have regular examinations than those who live shorter (44.4%) (Table 2).

To be healthy, Hoa Nguyen always follows up his health condition and frequently visits his primary doctor:

> I often go to the doctor's at least once a year to check my health condition. Recently, my doctor recommended that I should visit him twice a year because I am over 67 years old. Visiting the doctor is a very good way to protect my health.

Like Hoa Nguyen, Anh Nguyen is very cautious to take care of his health status:

> It is important to have physical examinations annually. The body is like a machine, which needs to be checked regularly. I have a physical examination regularly, to check my health and to see if anything is wrong, so I can be treated early.

Healthcare workers (100%) (Interpreter, health educator, health case manager) working directly with the Vietnamese are more involved in the American healthcare system than other groups because of their better language skills, accessibility, knowledge,

Table 2. Doctor's Visits by Sample Group

	Total Participants	Annual Examination		Doctor Visits (2-3 times & over per year)	
		N*	%	N*	%
Age					
30-44	7	2	28.5	2	28.5
45-59	4	2	50.0	3	75.0
60-75	3	3	100.0	3	100.0
Sex					
Male	7	4	57.1	4	57.1
Female	7	3	42.8	4	57.1
Education					
Elementary School	3	1	33.3	1	33.3
Junior / High School	6	3	50.0	2	33.3
College	5	3	60.0	5	100.0
Time in America					
Before 1992	5	3	60.0	5	100.0
After 1992	9	4	44.4	3	33.3
Income					
Under $20,000	3	1	33.3	1	33.3
$20,000-$39,999	8	4	50.0	4	50.0
$40,000 +	3	2	66.6	3	100.0
Totals	14	7	50.0	8	57.1

and increased contact with American culture. To maintain good health, Ngoc Dung always sets up a annual plan to visit her primary doctor:

> I always go to my primary doctor each year to check up on my general health. To remember my appointment, I always book an appointment after my birthday. Celebrating my birthday reminds me to maintain my good health and healthy life.

Xuan Vo also has regular checks up:

> Every year, I must go to my primary doctor for a check up. This is the best way to keep my body healthy.

Some Vietnamese do not go to the doctor regularly because they have a different idea from the American's. They rely on their own health knowledge, rather than on medical research. Chau Toan explained the reasons he does not have annual physical examination:

> I often go to the primary doctor's once every two years, not once a year as other Americans do. I do not need to have annual examinations because I have some

> knowledge of the condition of my own health. I always follow up on the state of my health.

Regular examinations always require time and an appointment. Minh Le does not like to have regular check-ups because he must have an appointment. If he makes an appointment, he has to wait four to five weeks to see the doctor:

> I do not go to the doctor's for regular visit, you know, because I must spend a lot of time to have an appointment, I'm put on a waiting list, then I must sit in the waiting room before the examination, even though I have no symptoms of illness.

In short, the low rate (50%) (Table 2) of Vietnamese adult and elderly who have annual examinations in Greater Springfield indicates that they have not much involved in the American healthcare and still keep their own health culture.

As for doctor visits when they are sick, like in Vietnam, many of the sample groups only visit the doctor if they have symptoms, or if their symptoms become serious. Those who have lived in America for longer periods of time (100.0%) have more doctors' visits than those who have been here for shorter periods (33.3%) (Table 2). The young are most likely to neglect visiting the doctor, although many of them speak English fluently. Only two (28.5%) out of seven respondents ages 30 to 44 visit the doctor two or three times or more a year, compared with three (75%) of four respondents ages 45 to 59, and three (100%) of three respondents ages 60 to 75 (Table 2). Working for the Vietnamese community, Xuan Vo knows the young neglect having doctor's visit. She said:

> I have worked for the Vietnamese community in Springfield a long time and know that at least 40 to 50% of Vietnamese young people in Springfield do not go to the doctor.

Having a low income affects healthcare access. Those who have low incomes are likely to have fewer doctors' visits than those who have high incomes (Table 2). The

Vietnamese community in Greater Springfield is younger than other ethnic groups, based on the period of time it has been resettled in the United States. Most Vietnamese who came to the United States after 1975 (Vietnam War) are in low-income groups. As new arrivals, Vietnamese refugees and immigrants have priorities to resolve their urgent daily needs, such as shelter, food, and money to support their relatives in Vietnam instead of paying healthcare costs. As a health care coordinator in the community, Bien Tran knows why Vietnamese adults and elderly do not keep appointments:

> Many Vietnamese in Greater Springfield are negligent of their healthcare. They pay attention to their jobs rather than their health. They work all days from 7 A. M. to 5 P.M. and have no time for it. Many do not regard their appointments, not even reading the appointment paper reminding them to visit the doctor.

Vietnamese who have more education level have many more doctor visits than those who have less. Five (100.0%) of five Vietnamese respondents who have college school level visit the doctor 2 and 3 times a year, compared with two (33.3%) of six respondents who have highs school level and one (33.3%) of three respondents who have elementary school level (33.3%) (Table 2).

If Vietnamese adults and elderly are likely to neglect a doctor's visit (57.1%) (Table 2), they are actively involved in visiting the specialists when they have severe health problems. All Vietnamese also give a priority to treating their serious diseases, even though their treatment can mean enduring a long regimen. Tuan Khanh said:

> We must go to doctor if we have disease such as cancer or stomachache, to be treated as soon as possible. In such situations, we know that the only way save our life is to go to the doctor. We cannot delay.

Basically, culture influences Vietnamese adults and elderly to get involved in the American healthcare system. The number of doctor visits of the Vietnamese adults and

elderly also depends on age, sex, education, income, and the period of time living in America (Table 2).

Behavior of the Doctor

The doctor's behavior influences healthcare access and the level of involvement for Vietnamese. They visit healthcare providers more or less often, depending on whether their doctors take care of them and help them to make the right decision.

In general, American healthcare providers have many positive attitudes in healthcare access for Vietnamese. Hoa Nguyen has sympathy with his American healthcare providers because he is polite and funny:

> My doctor is a Japanese American. He has many cultural characteristics similar to the Vietnamese. He is funny. He is a nice guy.

Many American doctors are courteous. They always welcome their clients with a handshake or a smile. This attitude makes the Vietnamese, who always consider the doctor as a superior, feel safe and open-minded toward him. Together with courtesy, American doctors are very patient. They listen to their clients, even though Vietnamese patients are accustomed to expressing their diseases in miscellaneous terms. Having sympathy with the American health provider's behavior, Hoang Nien said:

> Vietnamese patients are accustomed to talking in detail about what is going on with their symptoms to their American doctors, even the old diseases they had before. They would like their doctor to know their medical history so they will have a precise diagnosis. American doctors may find it difficult to listen to them, but try to follow up what their clients say.

Like Hoang Nien, Chau Binh explained:

> In Vietnam, many Vietnamese doctors are impatient with their clients. For instance, if I expressed my symptoms, he asked me only to resume it. How could he treat my illness if he did not know my illness history? On the contrary, in the United States, the doctor is more patient. He can listen to what I want to express about my symptoms.

However, American doctors also have many negative attitudes when working with the Vietnamese. By not valuing cultural differences, many American health providers can cause misunderstandings, miscommunication, and even misdiagnoses for the patients. Many Vietnamese do not dare to have eye contact with their doctor because in the Vietnamese culture the doctor is considered superior. When their doctor has eye contact with them, they feel uncomfortable and cannot tell the doctor all they want him to know. Because of language barriers, Vietnamese adults and elderly cannot express their symptoms fully to their doctors. At the same time, the doctor is not able to explain all to the patient. The interpreter is necessary, but many times, information through the interpreter cannot express all that is needed between the patient and the doctor.

Many Vietnamese feel uncomfortable when visiting the doctor because they must wait a long time in the doctor's office. One doctor usually takes care of many patients, so he has difficulty staying on time with the other patients. Those who have a lot of contact with American healthcare have a different view of the doctor's behavior. The doctor's examination is complicated and takes time. Based on X-rays, laboratory tests, and ultrasounds, the American doctor's diagnosis is more precise; but the procedure requires an extended period of time and a lot of paperwork. According to Hoang Nien:

> The American doctor is too cautious in his examination and in giving prescriptions. He wants to see me again and again, and take a test again and again. It is a waste of time. He spends more time on his diagnosis than the Vietnamese doctor does. My eye doctor never gives me prescriptions, although I ask him.
>
> Last month, my mother had to go to the emergency room for her health problem. I did not know why the nurse took blood tests five and six times that day. A blood test is good, but too many is not good.

Compared with Western healthcare in Vietnam, Hoa Nguyen thinks that the American healthcare system is too complex:

> American doctors are only specialized in their careers, not knowing the others'. For instance, the doctor who specializes in the treatment of heart disease only knows about the heart. The system is like a part of diagram connected together to make a machine. If something is wrong in this diagram, it will influence other parts, and all the parts will collapse.

Those who contact with the American healthcare system or deliver healthcare for the Vietnamese community have a different view of American doctors. Though every patient's illness is in a different situation, the American doctors do not use their knowledge and talents to discover new methods to diagnose for each patient; rather, they always depend on the formulas already used in medical research or in laboratory tests. If the patient has a reaction to a treatment regimen, such as a side effect, the specialist again changes to another medicine. Tuan Khanh expressed:

> I have a feeling that the American doctor (specialist) seems to use human being as an experiment. For instance, if the client is a TB active case, OK, it takes six months with four drugs. If they have positive skin test and X-ray is normal, O.K, it takes nine months with INH for preventive therapy. If illness is not decreased, OK, they must change to another regimen. If only depending on laboratory tests to examine the patients, the American healthcare provider may not be more talented than a Vietnamese doctor. American doctors do not try to learn more, because they have medical technology formulas already to support them.

Even sometimes, American healthcare providers give the wrong diagnosis. Every year in America, there are 8,000 cases of wrong diagnoses or doctor's becoming confused when performing surgery or operations. For instance, the doctor forgot something inside the patient's body after surgery. In Texas recently, a teen-ager died during an organ transplant. Instead of type O blood, she was transfused with type A blood (Dalesio, 2003). In New York City every year, dozens of babies died or live with brain damage through the mistakes of the doctors and midwives who deliver them (Spector, 1996). In reaction to Western healthcare services, Lan Nguyen said:

> I often visit my primary doctor because I always have a headache. Whenever I go to the doctor, he always says that I have no illness (After quickly reviewing the x-

ray film). I am wondering about my doctor's diagnosis. If I have no illness, why should I continue to have a headache?

In short, when providing healthcare for the Vietnamese, American healthcare providers have many positive as well as negative points. The doctor's behavior influences the level to which Vietnamese get involved in the American healthcare system. Only 50% of respondents said that their doctor's behavior was very good. This influence depends on sex, age, education and time in America. The old believe much more in the doctor than the young. Those (80%) who live in America for a longer time believe much more in the doctor than those (33.3%) who live here for less time (Table 3).

Table 3. American Doctor's Behavior Towards the Sample Group

	Total Participants	Doctor's Care for Patient (Very Good) N*	%
Age			
30-44	7	2	28.5
45-59	4	2	50.0
60-75	3	3	100.0
Sex			
Male	7	4	57.1
Female	7	3	42.8
Education			
Elementary School	3	1	33.3
Junior / High School	6	3	50.0
College	5	3	60.0
Time in America			
Before 1992	5	4	80.0
After 1992	9	3	33.3
Income			
Under $20,000	3	1	33.3
$20,000-$39,999	8	4	50.0
$40,000 +	3	2	66.6
Totals	14	7	50.0

Healthcare Treatment

Many Vietnamese adults and elderly of Greater Springfield use different forms of healthcare than Americans. They are inclined to self-treatment. When experiencing any

symptoms of disease, Vietnamese like to treat themselves before seeking the interventions from the American healthcare system.

Self Treatment and Self Adjustment

Vietnamese in Greater Springfield cannot easily renounce the way they treated their illnesses when living in Vietnam. Most adults and elderly continue to use self-treatment. When sick or experiencing symptoms (fever, cough, headache), Vietnamese like to take some over-the-counter medicines bought in the drug store, such as Advil, Tylenol, or some traditional medicine. Hoai Dinh believes that this treatment is convenient, saves time and money, and will not impede his daily activities in family and society.

> As an immediate response to sickness, I prefer to take some over-the-counter medicines from the drug store. If you call the doctor and wait for him to answer, may be your sickness becomes more serious.

Vietnamese adults and elderly believe that many illnesses are caused by weather changes, especially the transition time between winter and summer, in which people easily get cold or flu. If they have a flu or a cold, the better way for them is to let the immune system in the body treat itself, using self-adjustment instead of medicine. They do not understand that the flu, if not treated in time, can cause pneumonia, influenza, or other complicated diseases. Yet, according to Anh Nguyen:

> Through experience, we know that the best way to struggle against the flu and cold is to let the immune work against it. Self-help treatment is a good way to treat common cold or flu. If not available, we will use medicine later.

Although using American healthcare, some Vietnamese, especially the middle aged and elderly, like to have self-adjustment to medicines and do not follow what their doctor recommends. The doctor often writes the prescription and the amount of medicine based on the patient's weight, but not everyone follows the doctor's recommendation and

prescription. In the sample, Hoang Nien prefers to adjust the medicine dosage to what she believes is good for their body:

> I have high blood pressure. My doctor recommended me to take one pill a day. I know that I am thin and short. How can I take a pill like an American? After trying a dose, I felt dizzy; therefore I only take a half.

Many Vietnamese are scared to use chemical substances of Western medicine, which can cause side effects such as heart attack or liver damage. They like to try self-adjustment. For instance, when taking high blood pressure medicine they may begin to feel "hot", they then try to adjust the dosage (one pill a day instead of two pills a day). The problem is that many Vietnamese adults and elderly do not dare to tell the truth to the doctor about their adjustments, even when their doctor asks them. Many Vietnamese adults and elderly are inclined to keep medicine that is left over after treatment. For instance, the doctor gives a prescription for a one-week regimen for headache treatment. After taking the medicine three or four days, if the headache is gone, the Vietnamese like to stop taking it and use what is left next time if they have the same symptoms. In doing so they save time and money. Xuan Vo, who works in the Health Center as an interpreter, knows clearly about the self-adjustment behavior of the Vietnamese:

> Vietnamese often adjust their dosage of medicine. They try to conserve medicine when the same illness will occur again. Another problem is that they not only have self-adjustment, but also give the remaining medicine to their family members, or mail them to Vietnam for their relatives, especially high blood pressure and diabetes medicines.

In short self-treatment and self-adjustment still influence Vietnamese adults and elderly. However, self-adjustment is likely to be at a low level, because only two (14.2%) of the respondents continue to use self-adjustment when taking medicines (Table4).

Table 4. Health Treatment of Vietnamese Adults and Elderly

	Total Participants	Self Treatment N*	Discharging Medicine when Symptoms Disappear N*	%	Visiting the Doctor or Hospital with a Serious Health Condition N*	%
Age						
30-44	7	7	4	57.1	5	71.4
45-59	4	4	3	75.0	3	75.0
60-75	3	3	3	100.0	3	100.0
Sex						
Male	7	7	5	71.4	6	85.7
Female	7	7	5	71.4	5	71.4
Education						
Elementary School	3	3	3	100.0	3	100.0
Junior / High School	6	6	4	66.6	5	83.3
College	5	5	3	60.0	3	60.0
Time in America						
Before 1992	5	5	2	40.0	3	60.0
After 1992	9	9	8	88.8	8	88.8
Income						
Under $20,000	3	3	3	100.0	3	100.0
$20,000-$39,999	8	8	6	75.0	6	75.0
$40,000 +	3	3	1	33.3	2	66.6
Total	14	14	10	71.4	11	78.5

* 100% of the participants in this study did some kind of self treatment on a regular basis.

Visiting a Doctor for Serious Illness

Vietnamese adults and elderly have inclined to go to the doctor or to the hospital when their health condition becomes serious. Not every Vietnamese is aware of the danger of disease or the benefits of prevention. Generally, at the preliminary period of disease, when having some symptoms, many Vietnamese do not go to the doctor for an examination, thinking that it is a general illness, and some over-the-counter medicines will be sufficient to treat. People may die if they wait too long to visit the doctor too late. Recently in Springfield, a Vietnamese lady named Ph. who had headache for a long time, tried to go to work and worked hard every day. When her condition finally made her

unconscious, her family brought her to the hospital. At that time, the doctor found that she had cancer and she only survived a few more months.

Vietnamese in Greater Springfield are at high risk for Hepatitis B. There are more than a hundred Hepatitis B carriers in Springfield (Springfield Health Department and Human Services, Smith Center). Most people were infected with Hepatitis B when they lived in Vietnam. No medicine is effective in treating a Hepatitis B carrier. The most effective treatment is through controlling the diet which includes no alcohol, avoiding stress, relaxing, and following up with ultra sound procedure. Many infected people do not regard the risk until their health become serious. They hurry to the doctor but too late. At least three Vietnamese in Springfield died because of Hepatitis B in recent years.

Bien Tran who worked for a long time in the Vietnamese community as a case manager expressed his feelings about Vietnamese healthcare treatment:

> Vietnamese have not valued their health. They work hard to save money. They do not worry about their symptoms of diseases. When things are serious, they visit the doctor. But it is sometimes too late. Their disease becomes serious and hard to treat.

Along the same idea as Bien Tran, Chau Toan expressed his feeling toward healthcare access by Vietnamese:

> The Americans are very excellent in protecting their health. If having any health symptoms, the Americans will go to their doctor and know how to explain to him. Vietnamese, if having such symptoms, try to endure them until they cannot.

Many Vietnamese adults and elderly disregard the doctor's examination, and especially urge the primary doctors to refer them to a specialist when they have some symptoms. Bien Tran was very confused and regretted his behavior when he had a serious eye problem:

> I only went to the doctor to have an eye examination. I did not know that I might visit the eye specialist who has knowledge and experience to take care of my

> eyes. When my eye had a problem, water always ran out. I talked to the optometrist. The optometrist referred me to the specialist. It is too late. I should go to the clinic to have surgery.

Vietnamese adults and elderly often go to the doctor when they are ill. This fact causes much confusion for the healthcare providers and the staff in the hospital, because they consider Vietnamese clients to be like many other ethnic groups, who come to the emergency room to get symptoms treated as quickly as possible, even though they are not in serious condition. Unlike other ethnic groups, when Vietnamese go to the emergency room, it means they are really in serious condition. Being made to wait too long in the emergency room can make many Vietnamese hesitant to go to the clinic or hospital in the future, and so endanger their life. In 2002, one victim of emergency rooms, Mr. Kh., a Vietnamese, had a stroke. His family immediately brought him to the emergency room at the hospital. He had to wait for four hours, until his condition became serious. The doctors finally examined him and apologized for their delay. Now Mr. Kh. is permanently paralyzed from the neck down.

Hoang Nien describes the problems in the emergency room when she brought her family members to the hospital:

> There was no way to rescue my mother. So I had to bring her to the emergency room. But unfortunately, the staff in the emergency room worked very formally, not responding to the patient. The process in emergency room was too slow. Paperwork was complicated; and she waited to be examined for too long a time, three or four hours.

Many Vietnamese do not care to improve their health. They are inclined to get involved in healthcare only whenever an urgent situation occurs. In many TB active cases, the household contacts (including children) rushed to have the skin test or go to the TB clinic for a doctor's examination because they were frightened of being infected although in the past many times they refused.

Discharging Medicines if the Symptoms Disappear

Like in Vietnam, Vietnamese adults and elderly are inclined to take medicine when they have symptoms. If their symptoms go away, they will stop taking it and think the disease is gone. They do not know that although symptoms disappear, their disease still exists. Viruses or bacteria in their bodies are only temporarily dormant, and will react against the body soon.

Working with TB-infected Vietnamese, health workers must confront many patients who do not want to continue their regimen because the symptoms of disease have disappeared. The TB regimen often requires nine-months of INH (IZONASID) for prevention and six months with four drugs (Rifampin, INH, Ethambutol, PZA) for active TB cases. If the patient only takes medicine until symptoms disappear (often two weeks), TB bacteria are only dormant, and will revive to further harm the patient.

To control tuberculosis and TB active cases, healthcare workers are assigned to administer Directly Observed Therapy (DOT) to those who are active cases. Every day, the worker must observe that the patients to take the drugs, for six months or more, until their X-ray films are clear.

When administering DOT, healthcare workers encounter many problems. The patients often are disappointed when the health worker comes to their house for DOT. In Vietnamese culture, if you go to observe what people do, it means you do not believe them, or want to control them, especially the old, who are respected in their community. Daily observation also disturbs the family. Vietnamese are still afraid of TB, because it can cause infection in others. They still think the patient needs to be isolated from daily family activities such as eating, washing, and sleeping. Those who are infected with TB

active cases do not let anyone know their health problem, because they are afraid of friendship or marriage break-ups, even though the healthcare worker tries to educate them.

In general, although living in America, Vietnamese adults and elderly are unlikely to adjust easily to the American healthcare system. In healthcare treatment, Vietnamese still keep self- treatment (100%). They often discontinue taking medicine when symptoms disappear (71.4%), and only go to the doctor or hospital when in serious condition (78.5%). The level of their own healthcare treatment also depends on age, sex, education, income, and period of time in America. The male is more likely to have more doctor or hospital visits (85.5%) when in serious condition than females (71.4%) (Table 4).

Disease Prevention

Everyone agrees that health is better if the disease is discovered early and treated immediately. In so thinking, the American has a priority for disease prevention. Every year, the U.S. government spends billions of dollars on prevention programs. The benefits of health prevention are significant. Health prevention is a good way to save lives and health costs. Vaccination and immunization can prevent diseases that are hard to treat if found out late, such as cancer and heart disease. Thanks to prevention, every year the American healthcare system saves billions of dollars by controlling many diseases.

The American healthcare system encourages people to visit the doctor at least once a year to check on their entire health condition. The Department of Health and Human Services (State and Federal) has designed many prevention programs such as the

Tobacco program, lead poisoning program, and cancer program. These programs are disseminated everywhere on television, in newspapers, and in magazines. The government also gives grants to many non-profit organizations and agencies in local communities to expand disease prevention. Many primary doctors often recommend that their patients (men and women) have prostate, mammogram, breast, and Pap smear examinations, to find cancer early.

Vietnamese and Disease Prevention

In Vietnam, Vietnamese adults and elderly are not likely to be actively involved in prevention programs. Buddha and Confucius teach people to endure their fate. Disease is a result of ambition; those who avoid ambition will be healthy. Confucius also recommends people keep order in society and harmony with everybody. Taoism teaches people to blend in with nature and avoid societal involvement.

Influenced by their culture, many Vietnamese adults and elderly of Greater Springfield are not actively involved in prevention. Only six (42.8%) of the 14 respondents participate in prostate and breast prevention programs. These respondents have breast cancer and prostate cancer examinations every year (Table 5).

Being unfamiliar with prevention, Vietnamese adults and elderly of Greater Springfield still believe nature will help the body heal and fight against diseases. Disease is due to the imbalance of "Hot" and "Cold." The balance of these two opposites is necessary for a healthy life. Chau Toan believes that vaccination for immunization is good, but not necessary:

> I do not give much consideration to prevention. I visit the doctor every two years. I try to focus only on what the doctor recommends. I believe in the healing capacity of the body. The reaction of the body is miraculous. Relaxing is a good way to have good health.

Table 5. Use of Preventive Testing and Vaccination by the Sample Group

	Total Participants	Flu, Pneumonia Vaccinations		Prostate, Breast, Pap Smear Screening	
		N*	%	N*	%
Age					
30-44	7	1	14.2	1	14.2
45-59	4	2	50.0	2	50.0
60-75	3	2	66.6	3	100.0
Sex					
Male	7	4	57.1	4	57.1
Female	7	1	14.2	2	28.5
Education					
Elementary School	3	0	00.0	1	33.3
Junior / High School	6	2	33.3	2	33.3
College	5	3	60.0	3	60.0
Tim in America					
Before 1992	5	3	60.0	4	80.0
After 1992	9	2	22.2	2	22.2
Income					
Under $20,000	3	0	00.0	1	33.3
$20,000-$39,999	8	3	37.5	3	37.5
$40,000 +	3	2	66.6	2	66.6
Totals	14	5	35.7	6	42.8

Many Vietnamese adults and elderly are not aware of the benefits of prevention. They consider prevention less urgent than food and shelter. They spend most of their time working, and have no time for prevention screening.

When resettling in America, every new arrival, especially refugees, must go through health assessments, including a skin test, blood work, and other tests, to find any health problems. If they have a positive skin test or an abnormal chest X-ray, they should be treated. Generally, if the skin test is over 10 mm, they must have preventative treatment for at least from 9 to 12 months with INH. Huong Le is not accustomed to the new treatment, and had this reaction to the regimen:

> I tried to take medicine for TB prevention, because my test was positive. I am not sure if I was infected because I have no symptoms. The doctor recommended that I take INH for nine months. To me, the nine months INH regiment is too long

Prevention and Vaccination

Prevention by vaccination is widespread in the United States. Many health campaigns are promoted on television, and in newspapers or magazines, to get every American involved in prevention. The United States has had prevention programs for a long time. A small pox vaccine was mandatory in 1915; diphtheria vaccine began in 1933; tetanus, (1940); and measles, mumps, and rubella in 1963 (Spector, 1996). In the Department of Health and Human Services in the city, there are annual healthcare programs for the elderly to vaccinate against flu and the common pneumonia. Children, too, are especially taken care of by immunization, from when they are just born until 18 years old. To Minh Le, vaccination is not a priority in his life, he rarely goes to the doctor to have flu or pneumonia shots:

> Vaccination is very good. It prevents me from catching flu or pneumonia. Many Vietnamese have the flu in Springfield when winter comes. The problem is that I must work. If I have a shot, I must have an appointment and take a day off

Many Vietnamese adults and elderly who are not concerned about health maintenance only do what the doctor recommends, and are not proactive in improving their health condition. Meanwhile, they also think that the doctor, influenced by health insurance policies, does not want more health improvement for the patients because of high healthcare costs. In reaction to this fact, Lan Nguyen said:

> Because my primary doctor did not recommend me to get a flu or pneumonia vaccination, and did not make an appointment, I think my health is OK.

The United States is not a country at high risk of Hepatitis B. The Health and Human Services Department, together with the healthcare providers, does not have much concern about hepatitis B prevention. But Asians, especially Southeast Asians, are at high risk of Hepatitis B. The rate of death due to Hepatitis B is very high. Most adult deaths in

the Vietnamese community recently were caused by Hepatitis B. Hepatitis B vaccination for Vietnamese in Springfield is not likely to be offered because the American primary doctors do not have much concern about it. In dealing with this problem, Hoang Nien said:

> I have lived in America for ten years. I have never heard from my primary doctor about Hepatitis B prevention. My doctor only takes care of me and gives me a shot when I request it. I think that Hepatitis B prevention with three shots is expensive; so the health insurance company is not concerned if the patient does not request it. Because I can speak English, I am able to deal with the doctor about the vaccination. How will others who cannot speak English deal with their doctors?

In 1998 several adults with Hepatitis B died in the Vietnamese community. The Southwest Community Health Center received funding from the Massachusetts Department of Public Health for a Hepatitis B immunization campaign. This campaign combined many organizations in the community including the Vietnamese American Civic Association, the Vietnamese Veterans Association, the Buddhist temple, and the Vietnamese Holy Name Catholic church. Everyone participated fervently, but after the campaign ended, the immunization program did not continue.

Colonoscopy is a test for intestinal cancer. Every five years, an adult should have this test. Unfortunately, many Vietnamese do not know it. They only get a test if they are showing symptoms. In this situation, it is too late for treatment. According to Huong Le:

> I have lived in the America for eight years. I have a primary doctor since I came to the United States. But I have never heard of colonoscopy.

Breast cancer is a serious health problem for women. Every year, breast cancer kills millions of women in the United States. The American Cancer Society (2001) recommends that females 40 years old and over get annual clinical breast cancer examinations and females from 20 to 39 years old get a clinical breast cancer

examination once every three years. For males age 50 and over, an annual prostate cancer examination is recommended.

In America, Vietnamese adults and elderly are likely to be unfamiliar with breast cancer or Pap smear examinations. They rarely go to a doctor or specialist for examinations. A Vietnamese female is very hesitant to let someone examine her body. Hoang Nien confessed:

> Living in the United Stated since 1992, I only went to the doctor for breast and Pap smear examination once. I felt very uncomfortable when being screened.

Basically, Vietnamese adults and elderly do not get involved much in preventative healthcare, although prevention is important in keeping everybody healthy. Only 42.8% of respondents have prostate, breast, or Pap smear screening, and 35.7% have flu shots or pneumonia shots annually. However, their involvement in health prevention also depends on age, education, income, and time in America. The young (14.2%) have less prostate and breast cancer screening than the middle aged (50%) and the old (100.0%). People who have high incomes have more breast and prostate cancer examinations (66.6%) than people who have low incomes (33.3%). Those who have lived in America longer (80.0 %) have more examinations than those who have lived here a shorter number of years (22.2%) (Table 5).

Participation in Traditional Healthcare

Living in America, Vietnamese in Greater Springfield do not give up their traditional healthcare. On the contrary, they continue to seek their traditional healthcare to keep themselves healthy.

Many researchers confirm that those who get deeply involved in the host culture will neglect their traditional culture, and are more likely to adopt the culture of the host country than those who do not. Do Vietnamese adults and elderly of Greater Springfield change their use of traditional healthcare when they have contact with American healthcare? Can variables such as education, income, sex, and age influence Vietnamese adult and elderly access to traditional healthcare?

Traditional Healthcare Concept

The concept of health is an important factor influencing healthcare access of individuals or groups. Generally, ideas direct action, since people often do what they perceive or believe in.

Vietnamese adults and elderly of Greater Springfield believe traditional healthcare is good for their health. It is a basic need that cannot be replaced by any other kind of healthcare. Beyond American healthcare, traditional healthcare is seen as an additional strategy for the improvement of health. Hoai Dinh is happy to use traditional healthcare. He said:

> Although I use American healthcare, I continue to practice traditional healthcare because it is effective in treatment of illness.

Traditional healthcare is a way for the Vietnamese to balance "Hot" and "Cold." Changing life from a tropical climate region where the weather is either hot or raining to a country (America) with four seasons brings many challenges to health maintenance. To have a healthy life, according to Hoa Nguyen, Vietnamese need traditional healthcare to balance "Hot and Cold" more than ever:

> Living in America, where there are four seasons and where the winter is cold or freezing (in the Northeast), together with eating frozen foods (belonging to "Cold"), Vietnamese have more "Cold" than "Hot." Traditional health practices will help them to keep a balance of " Hot" and "Cold.

Chau Binh emphasized that traditional healthcare belongs to the Vietnamese culture; the ancestors appreciated it; the descendents need to keep it because it is good for them:

> Traditional healthcare has existed a long time in Vietnamese society. Our ancestors practiced effectively to treat many diseases. Now we continue to follow the ancestors.

One of the benefits of traditional healthcare is that it is very convenient. Vietnamese can use wild and cultivated medical plants and herbal vegetables for self-care that grow in their garden, on the sidewalk, in the forest nearby, or they can buy it from the Asian market in their community. In addition, in traditional healthcare practices such as using herbal steam and oil balm, Vietnamese can do it by themselves. To employ the complicated health practices such as cupping and coining, people only need help from their family or household members. If specialists are required, at least two Vietnamese traditional health practice professionals are available in the community ready to treat any patients at low cost and in a timely way. Huong Le confirmed the convenience of traditional healthcare access:

> Although having a primary doctor, I often use traditional healthcare. Because all materials for healthcare such as ginger, onion, pepper, and garlic are grown in my garden, I can use them anytime.

In agreement with Huong Le, Linh Pham gave an example in traditional healthcare access:

> Many times, when I feel uncomfortable, I go to restaurant, and eat a hot bowl of pepper spilled beef noodle. A few minutes later, I feel better because hot food causes sweat and pushes the cold out.

According to Anh Nguyen, traditional healthcare is not as expensive as Western healthcare. Medicine is made from herbs and plants, which grow in the garden or in the

wilderness. The health practices are simple. Only a quarter, some oil, and a cup are enough for practicing. He said:

> Traditional healthcare is not expensive. I can use ginger, onion, and some herbal plants for my herbal steam. Even if I take Chinese medicine, it costs about $20, including the examination and the medicine, compared with the Western medicine that costs hundreds of dollars.

Traditional health practices can be applied anytime, night or day, whenever the person has the symptoms. This is in contrast to Western healthcare, which requires doctor appointments and transportation. Vietnamese traditional health practices such as coining, cupping, and herbal exhaling are fast-acting against the disease. Linh Pham said:

> I like to use coining and herbal steam. These traditional health practices are very good because they act fast against the disease. I only need five minutes for coining and I will be better; meanwhile if I go the doctor, I must make an appointment, get on the waiting list, and then sit in the waiting room to visit the doctor. In the waiting time, my health problem could become serious.
>
> If traditional health practices work faster against illness than Western medicine, the traditional medicine and Chinese medicine are also slower in taking effect than Western medicine. Western medicine treats disease directly, and it only gets rid of the infecting organism. On the other hand, herbal medicine treats disease indirectly; this means it boosts the body's immune system against disease, rather than getting rid of the infecting organism, as in Western medicine (Lanahan, & MacLanahan, 2002). Bien Tran confirmed the benefits of traditional medicine last longer and are stronger than those of Western medicine:
>
> By my experiences, I know that people who have treatment with traditional healthcare have a regimen longer than Western medicine, but its effectiveness is longer and stronger than Western medicine.
>
> If traditional health medicine is slower in taking effect, it has fewer side effects than Western medicine. Every year, there are more than 100,000 fatal drug reactions

among American patients (Underwood, 2002). Hoa Nguyen believes that traditional medicine only boosts the immune system through natural medicine, as opposed to Western medicine, which contains many chemical substances:

> Traditional health medicine has fewer side effects than Western Medicine. For instance, in Western medicine, high blood pressure medicine can cause damage to the kidney, the urinary tract organization, or sexual impotence. The tuberculosis medicine can damage the liver function.

Although having many advantages, traditional healthcare can also have many problems that need to be solved to provide better health services for the Vietnamese. Traditional medicine and healthcare practices are not very hygienic. In coining and spooning procedures, for example, scratching too much can cause bleeding or infections. Hoang Nien thinks that herbal medicine is not dispensed systematically and not much sterilized, and only dried and conserved in an uncontrolled environment:

> Coining is very good; if the equipment, such as a quarter or a spoon, is not sterilized, it can cause infection.

Like Hoang Nien, Linh Pham said:

> I think that traditional medicine is not hygienic enough for safety, because many herbal medicines, especially liquid medicine, cannot be stored in a much sealed bottle, and the dry plant or herb is only put in a paper bag.
>
> Traditional medicine has also not been studied as much as Western medicine.

According to Linh Pham, many traditional medicines, although effective in treating many diseases, are limited by not having much support from research or experimentation, but only through verbal transmission from generation to generation. He said:

> Traditional medicine is good but has not been examined thoroughly. It cannot be effective in many cases. For instance, many medical plants such as broad-leaved plantain can treat bronchitis or persistent cough. But because their toxins cannot be withdrawn, they can cause poisoning. The government does not spend billions of dollars for traditional healthcare research as for the Western medicine. They always consider traditional healthcare as un-systematic, and not as valuable as Western medicine.

Traditional medicine only treats general diseases in the balance of "Hot" and "Cold," and is not effective for diseases from infection by bacteria and viruses, or health problems requiring surgery. Anh Nguyen said:

> Traditional medicine cannot heal those who are infected with bacteria such as tuberculosis. The only way to treat it is to use Western medicine.

Vietnamese adults and elderly of Greater Springfield still keep their own traditional healthcare, although they use American healthcare, because it is convenient, not expensive, has few side effects, and is especially effective.

Traditional Health Care Practices (Coining, Cupping)

Traditional health practices have existed for a long time in the history of Vietnamese healthcare. Vietnamese adults and elderly use traditional health practices as an effective means to improve their health.

Thirteen out of 14 respondents (92.8%) use traditional healthcare practices while they also participate in the American healthcare system. The use of traditional healthcare practices does not depend on sex, age, income, education, or time in America, but the level of involvement is different according to the sex and age of the individual, and the amount of time spent in America (Table 6). When contacting with traditional healthcare, Ngoc Dung tried it and likes it:

> Although influenced by American culture, I like to have traditional health practices because the benefits of traditional health are great. At first, I did not believe in it; but through contact with Vietnamese clients, I tried it, and feel very good.

Hoai Dinh talked about the reasons he uses traditional medicine:

> I used traditional health practices when I was young child. I remember my mother cupping me when I was sick. Since then, I continue to keep this practice because it is good for my health.

Coining, cupping, and herbal steaming are quickly effective in treating cold, fever, vomiting, and pain (Figure 4). However, different people use different practices. Many prefer coining to deal with fever, because scratching with strokes in coining will cause the "Wind" to escape the body quickly; others prefer cupping. Anh Nguyen likes coining from the North better than from the South. In the South, coining scratches directly on the skin of the patient, while coining as used in the North only massages it. He said:

> There are many health practices using coining and spooning, but I like the coining of North Vietnam. Coining from the North includes ginger fluid, wine, a silver quarter and a peeled, boiled chicken egg; all materials are wrapped in a handkerchief, then massaged on the pain area many times. If the quarter changes color from silver to black, it means the patient has "Wind."

Scaring caused by scratching (coining) can causes bleeding, Linh Pham likes to have herbal steam:

> I like herbal steaming better than coining, because by scratching, coining can hurt me and sometimes make me bleed and become infected. Coining also requires scratching on the back. How can I do myself on the back? Herbal exhaling is likely to get the "Cold" out completely, and is the safest one compared to coining or cupping. Therefore, many Vietnamese like to use herbal steaming.

According to Tuan Khanh, herbal steam is very good traditional health practice, because it can push "Cold' or "Wind" out more completely and more easily than coining. She said:

> Herbal steaming is very good. I use ginger, lemon grass, lemon, and put it in a pan of boiling water; then cover my body and the boiling water pan with a blanket for about 10 minutes. After herbal steaming, I feel healthy; all the "Cold" in my body has gone out through sweating.

Vietnamese middle-aged and old-aged people like oil balm massage. In order to prevent disease that comes from weather changes, especially in the New England region, Vietnamese like to use oil balm as a preserved medicine to respond to any symptoms they

Figure 4 Traditional Health Practices

Spreading oil before coining (Bôi dầu trước khi cạo gió)

White tape (Cao giấn)

Coining (Cạo gió bằng đồng hào)

Cupping (Giác hơi)

Spooning (Cạo gió bằng thìa)

Cupping (Giác hơi)

may have. Oil balm helps them relieve headache, fever, and a runny nose. Anh Nguyen considers oil balm as a need in his life:

> I am accustomed to oil balm. When working in the factory, I always bring Mac Phu oil in my pocket. Whenever I feel uncomfortable, I smell or rub my forehead and chest with it and I feel better.

How do Vietnamese understand the effects of healthcare practices like coining, cupping, pinching, and burning? Coining and cupping are ways to push "Cold" out of the body. Spreading oil on the affected pain area before coining, cupping is used to clear up bacteria or viruses. Hoang Nien thinks that that scratching in strokes aims to make the body warm, and the urine and blood circulate better. She stated:

> Coining makes the body warm and blood vessels open wide, helping blood circulate easily. The problem is that if the vessel is broken, the body may be infected and experience side effects. The blood, which comes back to the heart and lungs, gets oxygen and becomes red, and then continues to nourish the whole body.

Hoa Nguyen believes that when coining or cupping, the "Cold" goes out through the hair pores in the bruised area of the skin.

> When coining, all "bad wind" goes out through the hair pores in the bruised areas. The patient feels better at once.

To pull "Cold" out quickly and effectively, Vietnamese use "Le." "Le" means the pain location is cut and then a heated cup is applied, which causes a vacuum sensation inside it. When sucking, all the "Cold" goes out via the incision.

Generally, although using American healthcare, Vietnamese in Greater Springfield continue to use traditional health practices, and combine them with American healthcare to improve their health. The level of traditional healthcare practices access also depends on sex, age, education and income. The young (85.7%) use less traditional healthcare than the middle-aged and the old (100%). Males (100%) use more traditional

Table 6. Traditional Health Practices Among the Sample Group

		Total Participants	Traditional Health Practices *	
			N*	%
Age				
	30-44	7	6	85.7
	45-59	4	4	100.0
	60-75	3	3	100.0
Sex				
	Male	7	7	100.0
	Female	7	6	85.7
Education				
	Elementary School	3	3	100.0
	Junior / High School	6	6	100.0
	College	5	4	80.0
Time in America				
	Before 1992	6	5	83.3
	After 1992	8	8	100.0
Income				
	Under $20,000	3	3	100.0
	$20,000-$39,999	8	8	100.0
	$40,000 +	3	2	66.6
	Totals	14	13	92.8

*Coining, Herbal Exhaling, Cupping, Acupuncture

health practices than females (85.7%). Those who are high income (66.6%) use less traditional healthcare practices than those with lower incomes (100%).(Table 6) (figure 4)

Herbal Medicine for Self-Care Treatment

Herbal plants and vegetable medicines are effective in treating illnesses in traditional healthcare. Vietnamese use both herbal medicine and traditional healthcare practices in their healthcare access.

Together with traditional health practices, Vietnamese like to use herbal medicine to control diseases. Many vegetables, such as ginger, garlic, and onion, are used as medicine. Herbal plants from a garden are used most in treatment. Vietnamese people can uproot them for medicine anytime from their own gardens in summertime, or buy them from the grocery in the community. Herbal grass or plants in the wilderness are used the

least because many tropical herbal grass and plants cannot grow in a temperate area like America.

Ginger is one of the most used vegetables for medicine. Linh Pham likes to use ginger treat cough.

> There is a good way to treat cough. I eat grilled ginger or ginger sweet, which makes my body warm, and my cough lessens.

Lan Nguyen uses ginger to treat fever and cold:

> When I have a fever or cold, I like to use warm ground ginger mixed with white wine to massage on my forehead and my shoulders, or I drink a cup of hot tea mixed with ginger, and I feel better.

Like Lan Nguyen, Tuan Khanh said:

> I always use ginger to treat cold or fever. Sliced ginger with hot tea water and then adding some sugar makes my body warm.

Garlic is an herbal medicine that fights against infectious diseases. It helps the immune system against bacteria, germs, or viruses. Garlic treats arthritis, high blood pressure, and diabetes. Lemon grass is the best one for herbal exhaling and cleaning the hair. It makes the patient warm and drives out the cold. Many Vietnamese use lemon grass together with ginger in cooled, boiled water for shampoo.

Lemon is used both for food and medicine. It treats stomach upset, cough, headache, breast swelling and hard breathing. According to Linh Pham:

> Lemon is good for heath treatment. When I vomit or have poor appetite, I only take a cup of lemon sugar juice and I feel better. Even lemon leaves can treat cough and ease hard breathing.

Anh Nguyen is likely to use ginseng as a medicine to strengthen their health, especially after he works very hard and needs to recover their health. He said:

> Everyday I take ginseng mixed with tea, even at break in my workplace. It is very good because it makes me concentrate on my work and less sleepy. There are two

kinds of ginseng: American ginseng and Korean ginseng, but I like Korean ginseng because it is more effective and makes me more satisfied.

The problems for the Vietnamese in herbal medicine are that many herbal medicines only grow in the tropical areas; meanwhile they live in America with seasonal weather. For instance, the Vietnamese cannot find the tropical herbal plants and grass such as bamboo tree leaf for herbal steam, or leaves of the guava tree for treating diarrhea. In such situations they must use Western medicine instead.

At present, the Vietnamese in Springfield get involved actively in herbal medicine. They like to use "vegetable soups" from Dr. Tateishi, a Japanese doctor, which can treat high blood pressure, and especially lung cancer and liver cancer. He researched and studied over 1,500 types of herbs and plants and issued a formula, which combined five elements of Chinese medicine theory (metal, wood, water, fire, earth) appropriate to five organs (heart, liver, spleen, lungs, kidneys) and five colors (red, white, black, green, yellow). "Vegetable soups" are matched to specific vegetables: Green/daikon radish leaves, Red/carrot, Yellow/Burdock root, White/daikon radish, and Black/shitake mushrooms (Kazu, 2004). The "vegetable soup" was at first only used in the Vietnamese community in California then spread through Louisiana, Texas, and now to many states in America, because of its effectiveness. Many Vietnamese believe they have been healed of liver or lung cancer after taking the "vegetable soup" several times.

Although accessing American healthcare, Vietnamese adults and elderly of Greater Springfield keep their traditional health practices and medicine alive. The fact that 12 out of 14 respondents (85.7%) use herbal medicines for self-treatment tells us that cultural components have an important role for the Vietnamese in their healthcare choices. Vietnamese replace Western health medicine only if they cannot find traditional

medicine. However, the level of participation in traditional healthcare also depends on age, sex, education, and periods of time in America. The young (71.4%) use less herbal medicine for self-health treatment than the middle-aged (100%) and the old (100%). Males (100%) use much more than females (71.4%), and those who have lived longer in America (66.6%) use less than those who have lived here less time (100%) (Table 7).

Table 7. Use of Herbal, Chinese or Eastern Medicine by the Sample Group

	Total Participants	Herbal Medicine*		Chinese or Eastern Medicine**	
		N*	%	N*	%
Age					
30-44	7	5	71.4	3	42.8
45-59	4	4	100.0	2	50.0
60-75	3	3	100.0	2	66.6
Sex					
Male	7	7	100.0	4	57.1
Female	7	5	71.4	3	42.8
Education					
Elementary School	3	3	100.0	1	33.3
Junior / High School	6	5	83.3	3	50.0
College	5	4	80.0	3	60.0
Tim in America					
Before 1992	6	4	66.6	1	16.6
After 1992	8	8	100.0	6	75.0
Income					
Under $20,000	3	3	100.0	1	33.3
$20,000-$39,999	8	7	87.5	4	50.0
$40,000 +	3	2	66.6	2	66.6
Totals	14	12	85.7	7	50.0

*Self-help care using ginger, garlic, onion, lemon grass, etc.

**Provided by Chinese or Eastern health providers

Animal Medicine

Animal medicine is a good traditional medicine that is used to treat many diseases. Vietnamese in Greater Springfield only use animal medicine as an alternative for treating diseases that herbal medicine cannot. Wild animal medicine such as tiger bones, bear's gall is rarely sold in Vietnam. Only people who live in the highlands can hunt animals in the forests, or be in contact with hunters. Animal medicines often are

ordered from the eastern or Chinese health providers. In the United States, Vietnamese only occasionally use animal medicines as an alternative. Because animal medicine (except for honey) is rarely sold in American markets, it plays a small role in Vietnamese traditional healthcare. In the Greater Springfield area, only two of 14 respondents (14.2%) use honey as traditional medicine. Like many other animal medicines, the honey is not only a tonic medicine but also treats liver and bladder disorders, and gastric pain. According to Hoang Nien:

> Honey is good nutrition and good for treatment. Whenever I have a dry cough, gastric pain, or sleeping trouble, I take some drops of honey.

Americans do not use living or dried animals for medicine. In fact, Americans have created many establishments and organizations and even laws to protect animals. Hunting is limited, and using dried animals for medicine is prohibited. The Vietnamese who use it get animal medicine such as tiger bone jelly and bear's gall only when they go back Vietnam to visit their relatives; on the way back to America, they buy and bring their limited animal medicines concealed in their baggage. Huong Le visits her relatives in Vietnam frequently; she is very familiar with the regulations against importation of traditional medicine ingredients into America:

> Animal medicine such as tiger bone jelly, or bear's gall is considered as food, therefore it is very difficult to bring back to America. Customs in the international airport in Boston will take it away and there is a penalty fine to those who are found to have it in their luggage.

In other way, although animal medicine does not play an important role in Vietnamese Traditional healthcare access in Greater Springfield, it contribute to the improvement of Vietnamese healthcare.

Traditional Health Medicine Resources

To provide food and ingredients for herbal medicine, many Vietnamese in Greater Springfield like to grow their own vegetable. At least eight (57.1%) out of 14 respondents have gardens where food and herbal medicines plants are grown. They use plots along sidewalks in front of or behind their houses to plant these vegetables (Figure 5). Examples of such herbal vegetables are garlic, ginger, lemon grass, and onion. Chau Binh talked about the benefits of a vegetable garden to provide both food and medicine:

> I myself have a small garden in front of my house in the summer. I like to plant several medicinal plants such as ginger and garlic for both food and medicine. Growing my own herbal medicine is very convenient for me, because I do not need to go to the grocery store.

During the wintertime, Vietnamese would grow their medicinal grasses and vegetables in pots inside their houses, near a window for sunlight. Rare herbs such as corn mint and cockscomb mints are specially planted inside for the next approaching summer.

One of the locations supplying herbal medicines is the market. In Springfield, there are four Asian markets (Saigon Market, Dong Nai Market, Asian Market, and Forest Park Market), which provide herbal medicines for Vietnamese and other Asian people. Vietnamese food markets in Springfield provide both daily fresh vegetables and traditional medicines for the Vietnamese community. Herbal plants and traditional medicines occupy many sections of the stores. They are displayed in stacks, and include ginger, ginseng, herbal teas, and dried lotus seeds, packaged in multi-colored bags or boxes (Figures 6, 7, and 8).

Many Vietnamese people need to update traditional health information and research to improve their understanding, but, in America, books on eastern medicine are

rarely sold in bookstores. Therefore, the Vietnamese in Greater Springfield must order traditional medical books from Vietnam, and use them as references. At least two out of 14 respondents (14.2%) have their own Vietnamese traditional medicine books. Hoang Nien said:

> Last year, when I went back to Vietnam to see my relatives, one of my biggest concerns was to buy some medical books. Traditional medical books edited by Dr. Do tat Loi contain much information about herbal medicine plants. I need these books for reference.

In short, Vietnamese in Greater Springfield have an abundance of traditional resources to provide health medicine in responding to their health need. These resources play an important role in improving healthcare for Vietnamese adults and elderly and in helping Traditional healthcare exist in the American Healthcare System.

Figure 5 Vegetable Gardens

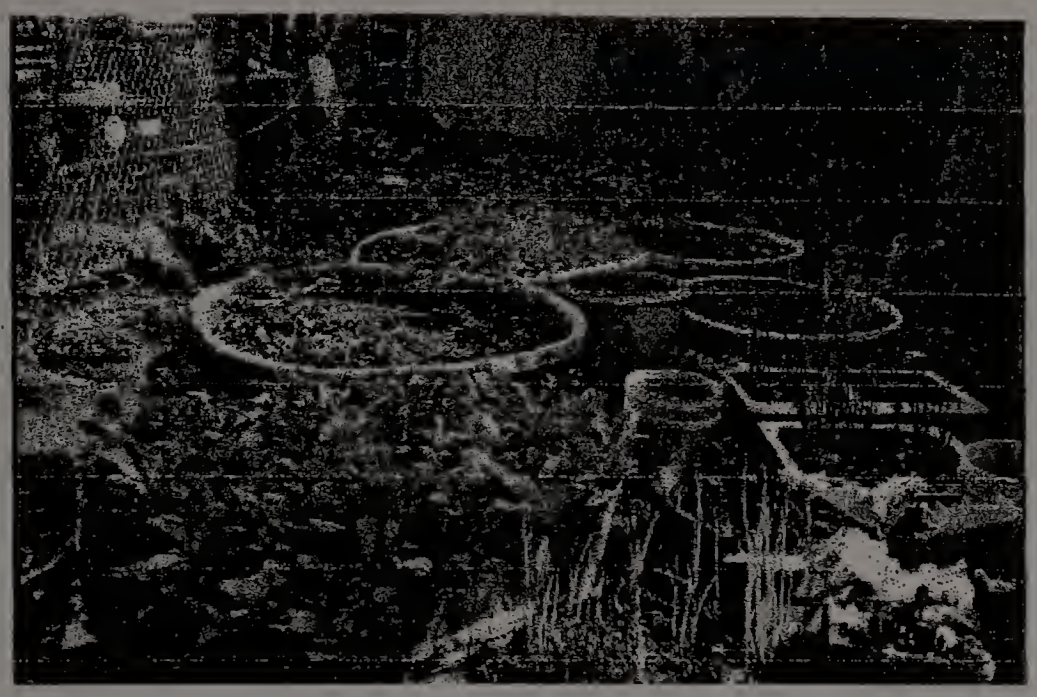


Figure 6 Vietnamese Food Markets in Springfield, Massachusetts

Figure 7. Herbal Medical Plants and Vegetables

Lemon grass, ginger.....

Welsh oinion, garlic, sweet potatoes

Figure 8. Herbal Medicines in the Vietnamese Markets

Vietnamese, Chinese, and Korean medicine

Vietnamese and Access Problems in American Healthcare

Like other ethnic groups, when adjusting to American healthcare, Vietnamese adults and elderly in Greater Springfield encounter many problems. In addition to time period in America, education, and income level, Vietnamese also face other problems such as getting doctor appointments, transportation, and the language barrier.

Making an Appointment

One of the factors that impedes adult and elderly from accessing American healthcare is the necessity of making healthcare appointments. In Vietnam, they did not need any appointment to see a doctor. They can go anytime during weekdays, and even on weekends. But in America, whenever they need to visit a doctor, an appointment is required. To those who cannot speak English, making an appointment is a problem. How can they contact a doctor's office if they cannot speak or aren't fluent in English? In this situation, the only solution left is to call for help from their children or relatives who can speak better English. Unfortunately, doctor's offices are only open during the daytime, when many Vietnamese must go to work or to school. It is possible for them to leave a message at the doctor's office, requesting an appointment, but then the doctor would need the details of the patient's symptoms before making a decision for the appointment. During treatment, or afterwards, the patient can have bad side effects, and need a doctor immediately, but he would have to make an appointment first, and if nobody were at home, who would help him do that? Chau Binh said:

> Many times, I would have liked to have an appointment with my doctor, but I could not make one. Because of my lack of English, my family makes the appointments for me; unfortunately, they must go to work, and the doctor's office is closed when they come back home.

Even to those who speak English fluently, making an appointment is still very frustrating, because they must also follow the doctor's schedule; and, often, the wait for an appointment is too long: two or three weeks or more. Meanwhile, the health problem requires a visit to the doctor as soon as possible. Linh Pham said:

> I do not like doctor's appointments because they are scheduled when I am working. If I have a health appointment, I must stay home and take a day off for my doctor's visit. I lose the benefits of a day's work. Meanwhile I feel I can continue to work.

For urgent care, Hoang Nien can call to see a doctor. But, unfortunately, many times she must only leave a message at the doctor's office, and wait for the doctor's response:

> Many times, I have called my primary doctor for urgent care, but I only make contact with the staff. The staff gives messages to the doctor, and I have to wait until the doctor responds. When the doctor responds, often three or four hour later, my symptoms have become serious.

Vietnamese in Springfield can call 911 or go to the emergency room when there is a serious health problem. But the hospitals in Springfield do not provide enough doctors in the emergency rooms, while the number of patients keeps increasing. Therefore, the patients must wait in the waiting room for a very long time, maybe three or four hours, to be examined. Many clients must wait too long and their health problems become serious, or even fatal.

Language and Transportation Barriers

Another problem for Vietnamese in their access to healthcare is the language barrier. Except for the young generation that is born or raised in the United States, most Vietnamese adults and elderly cannot speak English fluently. Amerasians, who are discriminated against in Vietnam because of their mixed race, and detainees who were officers in the Vietnamese army, cannot speak English fluently because the Americans only had contact with Vietnam since the Vietnam War (1959), and they worked with

Vietnamese officers in the army through interpreters. When living in the United States, Vietnamese adults and elderly have no opportunity to study English anymore. Therefore, when visiting the doctor, they often need interpreters. In recent years, the Southwest Community Health Center opened a branch in the Forest Park area, and supplied an interpreter for Vietnamese residents. It is very convenient to access healthcare for Vietnamese there, especially the elderly who cannot speak English; meanwhile Baystate Medical Center only has hired only one full-time, and Mercy Medical Center a single part-time Vietnamese interpreter.

A few years ago, the Vietnamese American Civic Association (VACA), a Vietnamese community center in Springfield, offered their services for interpreting for Vietnamese residents, but was not able to satisfy all their needs. Therefore, many Vietnamese must hire their own interpreters, which costs them money. But these services only respond minimally to the increasing needs of Vietnamese in their community.

In emergency rooms, by state law, a Vietnamese interpreter is required. But Baystate Medical Center, and Mercy Medical Center in Springfield only hire on-call or per diem interpreters who are not permanently in the emergency room. How can a patient be dealt with if there is no permanent interpreter in the emergency room? For specialist visits, the language barrier is also a problem. There are no interpreting services for minorities in specialist's offices. Every time a Vietnamese visits a specialist, his or her household members must accompany him, even children who have not been trained to be interpreters. Even those who speak English fluently may not understand all that the doctor tells them about their health, because they are not trained in the medical field to

respond in the same manner. Bien Tran confessed the language problems when going to the specialist's visit:

> Visiting a specialist is a problem. Although I speak English very well, I cannot understand all the medical terms. Therefore, I feel a distance between my doctor and me.

Language barriers always disrupt the communication between doctor and patient. Many patients cannot understand all of what the doctor tells them. They cannot express their feelings and symptoms easily to the doctor, so the doctor has limited communication with his patients. Understanding the problems of elderly when going to the doctor, Chau Toan said:

> Except for the younger generation that lives or was born in America, most adults who go to the doctor have a problem with the language barrier, even though they can speak English. Possibly, due to not understanding a medical word, a patient cannot express his or her symptoms or sickness to the doctor, and as a result, the doctor does not receive all the information needed about the patient's disease. Therefore, the sickness cannot be treated to the extent that the doctor and patient want.

Because of the language barriers, differences in American healthcare concepts, less experience in American society (10 years or under), with little or no schooling, and living separately within their own communities, many Vietnamese adults and elderly cannot understand the American healthcare system. Clearly, American healthcare is not meant for these people, Chau Toan continued:

> American healthcare is for those who speak English well. For instance, when dealing with a doctor, if you speak English fluently, you can understand his recommendation and advice. Even in the prescription, there are directions explaining in detail what to do if a patient has side effects, or any other problems.

To have better healthcare, the hospitals such as Baystate Medical Center and Mercy Medical Center need to hire Vietnamese healthcare providers and nurses to work with Vietnamese. Although the Greater Springfield area has a population of 7,000 Vietnamese,

no Vietnamese doctor or nurse works in the Baystate Medical Center or Mercy Medical Center. By removing language barriers, Vietnamese adults and elderly could more easily access healthcare if some Vietnamese primary doctor or nurses worked there. In our community, there is only one Vietnamese doctor. He works part-time in Springfield and half time in Worcester, and those who have him as a primary doctor find it hard to contact him because he is not resident in Springfield.

Transportation is another problem in Vietnamese healthcare access. Most elders in Greater Springfield cannot drive because, back in Vietnam, many Vietnamese never drove an automobile. Owning an automobile was a luxury and not necessary, like food or shelter. Living in America, most middle-aged or elderly Vietnamese cannot take the driving test because of their health conditions. So visiting a primary doctor or a specialist is not easy for the elderly. Their children cannot easily help them visit the doctor because they must go to work. The Vietnamese American Civic Association (VACA) can assist them but is limited by a lack of staff and vehicles. Taking a bus is not convenient for them because most doctors' offices are not along the bus route. According to Chau Binh:

> Transportation is a problem for me when I want to go to the doctor. My primary doctor's office is far from my house. Because my children are away all day, they cannot drive me to the doctor's office.

Time and Health Insurance Limitations

Time is an important factor of healthcare access. Like the American proverb that says, "Time is money," time is important for Vietnamese because they are new arrivals in America. Vietnamese must preserve their time to work and get as much money as possible. They need money to buy a car and a house, and be able to support their relatives in Vietnam. They go to the doctor only if their illness impedes their work. A day off to

the doctor is carefully weighed; even people who receive SSI or welfare benefits still go to work at under-the-table jobs because of their financial need.

Most doctor offices are open only during the daytime. If they go to the doctor, they must have a day off. They do not want to lose money from a doctor's visit if they feel it is not urgent, or if they can use another form of treatment such as traditional health practices.

Xuan Vo, who has been working as an interpreter in the Health Center for a long time, expresses her experiences of Vietnamese visits to the doctor:

> Many young and middle-aged Vietnamese in Springfield do not go to the doctor even though they have health insurance coverage. They do not want to have a day off for a doctor's visit if they feel that they can work.

Recently, in response to the Vietnamese health needs, the Southwest Community Health Center branch in Forest Park started a "walk-in" examination program for those who cannot visit at the regular times. Every Wednesday, the office opens from 12.45 P.M. to 7 P.M. This is a good time for those who work late. Aside from the Southwest Community Health Center, no other health offices have "after-hour" examination programs. Unfortunately, at the Southwest Health Center, the "after-hour" examination program is only on Wednesdays and only for clients of the Southwest Health Center. First priority is given to reserved patients, meaning other patients can only see the doctor when the reserved patients are finished.

Health insurance is necessary for healthcare improvement. The health status of individuals changes depending on their way of life. Health insurance is a good way to protect the health of everybody. Most Vietnamese in Greater Springfield have health insurance because of their job and Mass Health coverage; the problem is the limitations of health insurance. Most people who work in a company or for the government have

health insurance, but it often offers only 80% of costs. Hoa Nguyen compared Health New England and Kaiser Permanente coverage:

> My Health New England only covers 80% of the cost of medical treatment. Kaiser Permanente was better, but since Kaiser Permanente closed because of bankruptcy, I had to change to Health New England.

Xuan Vo in the Health Center shared her feelings about health insurance coverage:

> I am not satisfied with my health insurance because I must co pay too much, especially the cost of medicine.

To those who get Medicaid, Medicare, or Mass Health, healthcare coverage is a problem. Because of budget limitations, Mass Health, Medicare, and Medicaid only pay the minimum cost for health services. Many doctors and dentists do not accept Mass Health, Medicaid, or Medicare. Recently, due to the state budget cuts, many Vietnamese who have Medicare, Medicaid, or Mass Health did not have regular dental cleanings. Even dental services such as dentures, crowns, and root canals are limited.

In the Vietnamese community in Greater Springfield, at least one Vietnamese dentist does not accept Mass Health. This presents a problem because there are only two Vietnamese dentists available in the entire area. With one who does not work for low-income Vietnamese residents, how can the other possibly have enough time and energy to provide for this population in Greater Springfield?

All in all, language barriers, difficulty in getting doctor appointments, health insurance coverage limitations, and a lack of transportation are problems that prevent Vietnamese adult and elderly in Greater Springfield from using American healthcare. Combined with low income and low levels of education, Vietnamese adult and elderly people are not likely to be more active in their participation in the American healthcare system.

How Could the American Healthcare System be Better Integrated into Vietnamese Traditional Healthcare

In the United States, the relationship between Western healthcare and other healthcare systems has been controversial. Based on some side effects and a lack of research, many people think that traditional ethnic healthcare should not be used in America. Having this perception, a lot of Western healthcare providers are proud of their health system and have prejudices against others. They consider traditional healthcare as lacking in scientific research and controlled experiments, and believe absolutely that only Western healthcare is good for health.

On the contrary, much research indicates that traditional ethnic healthcare can co-exist with modern healthcare, and that traditional ethnic healthcare can support Western healthcare, even cooperate with it.

Kleinman (1978a) in the Healthcare system model stated that in a multicultural society such as the United States, traditional healthcare and American healthcare are related and support each other to improve healthcare for Americans.

In accessing healthcare, Vietnamese use both American and traditional healthcare. They stated that both could exist in American society. Almost all the respondents in this study confirmed that traditional healthcare and American healthcare are not contrary but support each other and can be combined.

Hoa Nguyen thinks American and traditional healthcare both have positive and negative points, and Vietnamese understand the value of each one. He said:

> In Vietnam, people live in a tropical region where there are two seasons, hot (dry) and wet (raining). Now resettled in the United States (New England), where there are four seasons, spring, summer, fall, and winter, they find that there is too much

> "Cold," especially at the end of winter. Any Vietnamese often combines two healthcare treatments together to balance "Hot" and "Cold" for survival.

In the same idea with Hoa Nguyen, Linh Pham explained more:

> A combination of Western and traditional healthcare is necessary because each system alone has advantages and disadvantages. We use them together to support each other. For example, chemotherapy is necessary for treatment, but physical exercise is also important to improve the health. Medicine is needed to treat high blood pressure but exercise is important to enhance the treatment.

One way Vietnamese use both healthcare systems at the same time is by combining the American and traditional healthcare to treat preliminary periods of illness. For a cough or a fever, the first thing Vietnamese do is to take over-the-counter medicines such as Tylenol and Advil. If the symptoms do not disappear, they use traditional health practices such as coining or cupping. Other Vietnamese like to use traditional health practices before using Tylenol. Some others combine both Tylenol and Advil at the same time. In combination, they believe their treatment has a dual effect. Traditional health practices remove "Cold" elements from the body, while Tylenol has the same function but disperses "Cold" or "Wind" that remains if coining is not totally effective. Finally, if self-treatment is not effective, Vietnamese will go to the doctor. A combination of traditional health practices and Western medicine is popular in the Vietnamese community. According to Linh Pham, traditional medicine is very convenient and often effective, not only to save time and cost but also to obtain quick relief:

> We think traditional and American healthcare do not contradict but support each other. The usage of traditional or Western healthcare depends on the conditions of the disease. If the patient is not in serious condition, we will use drug store medicine or traditional healthcare practices.

In a health situation that requires a doctor's examination, Vietnamese will call the doctor's office for an appointment. Unfortunately, a doctor appointment often requires at least a couple of days to book, one or two weeks in advance, except for a serious health

disorder that needs urgent care. During the waiting period until the doctor visit, healthcare practices are used to control the disease's symptoms. Talking about the benefits of traditional healthcare, Hoang Nien explained:

> While waiting for a doctor visit by appointment, we can use traditional healthcare practices such as coining, spooning, and herbal steam. By my experience, I think this is a good way to treat illness. If not, waiting until the appointment may be too late.

It is not likely that Vietnamese use traditional healthcare every time they have illnesses. By experience, they know when to use traditional healthcare and when to seek Western medicine. For instance, many diseases, for such as meningitis, in which the patient has an acute headache, one cannot use coining to rid of "Cold."

In many circumstances, through experiences, Vietnamese know not to use traditional health practices such as coining because chronic diseases cause the symptoms. For instance, if the patient has symptoms of high blood pressure, stroke, and heart disease, traditional healthcare is not used because these symptoms are not caused by "Hot" and "Cold." Anh Nguyen knows that traditional practices only resolve symptoms temporarily to take out "Wind" or "Cold." If the symptoms become serious, they cannot continue to use it. He said:

> Coining or cupping and other traditional health practices only resolve health problems temporarily. If health conditions are serious, the patient must go to the doctor, to urgent care, or to the emergency room only. For all diseases related to bacteria and germs, traditional medicine cannot treat them, like tuberculosis and AIDS. Any need for an operation must also go to Western healthcare.

Many Vietnamese often have the perception that Western medicines are "hot" (not related to temperature), and would decrease their energy if used in a long regimen. They believe that Western medicines only treat illness by clearing up the symptoms but do not strengthen the body. Meanwhile, Chinese, or eastern medicines, and traditional

medicine both treat and strengthen the body by helping the body to self-correct. Therefore, many people, during a long regimen of Western healthcare, would like to stop that medicine to take Chinese herbal medicine instead. After a couple of weeks, they will take Western medicine again, or after discharged from Western healthcare, they will use Chinese medicine ordered in Boston or Hartford. Hoa Nguyen explained:

> After discontinuing Western medicines, many Vietnamese would like to take Chinese medicine to strengthen their health, because they believe that the Western medicine is "hot." They need to take eastern or northern medicine to balance "Hot" and "Cold"..

Among 14 participants, seven (50%) use Chinese or eastern medicine after they have finished Western healthcare regimens. The use of Chinese medicine also depends on age, sex, income, and education. The young (42.8%) use it less than the old (66.6%). The high school and elementary school level of education uses less (33.3%) than the college level (60.0%). The low-income level uses less (33.3%) than the high-income level (66.6%) as well, because it must be ordered in Boston or Hartford, requiring time and money (Table 7).

In healthcare access, Vietnamese usually make an appointment with their doctor three or four days after using self-treatment or traditional health practices, if the symptoms do not disappear. Depending on symptoms, they will have an urgent care, emergency or regular appointment. In many circumstances, if the doctor in the hospital follows up with the patient and cannot determine the disease, the patient would be released. In this situation, the patient usually goes to a Chinese doctor or an eastern doctor for treatment because they believe that herbal medicine may save their life.

Recently, in the Vietnamese community in Greater Springfield, a Vietnamese young lady named H. had a severe fever, cough, and headache for a couple of weeks. She

went to Baystate Medical Center for treatment. After trying to make a diagnosis for two weeks using many blood tests, urine tests, and a biopsy, the doctor could not find any problem and let her go back home. Some friends advised her to see the Chinese doctors in Boston; after she took 20 bags of herbal medicine, she recovered.

In many cases, when the American doctor informs the patient that there is no treatment, and he must prepare to die, Vietnamese will return to the traditional medicine. At this urgent time, if their friends or anyone tells them of any traditional medicine, they would order as soon as possible. They think that trying various methods is the last chance if they do not accept their fate.

Vietnamese think that many diseases, such as arthritis, from which millions of Americans suffer, and which causes pain, stiffness, and swelling in joints, cannot be treated effectively by Western medicine. Every time they visit the doctor, they only get recommendations to try physical therapy and take some medicines such as Tylenol or Advil to reduce the pain. On the other hand, through experience, they know that traditional medicine is good for treating arthritis. Several years ago in Springfield, one Vietnamese named D. who had arthritis for a long time, went to a doctor for treatment many times but felt no better. By chance he met an old friend from California who gave him a prescription for an arthritis treatment. He mixed ground garlic into 50 grams of wine for ten days and everyday he drank 30 drops in the early morning and 30 drops in the evening before going to bed. A week later his back pains disappeared. He was very happy and has introduced this treatment to many people. At present, many Vientamese use this treatment for arthritis.

In general, Vietnamese adults and elderly of Greater Springfield know how to use both traditional and American healthcare. The two systems are not contrary but support each other to improve the health condition of Vietnamese.

American Healthcare and Alternative Medicine.

Today American healthcare is inclined to accept alternative medicine. Although many alternative medicines (traditional medicines) are not well evaluated by research, their benefits for healthcare are significant. Throughout its history, the American healthcare system has been pluralistic. Many traditional or folk medicines such as European folk medicine, Native American healing tradition, and African folk medicine existed together to provide healthcare for Americans. Later on, American capitalism had become a monopoly; so the healthcare system was also evolved from pluralism to a monopoly. The theory of germs became popular for treatment. Through the effectiveness of the germ theory in killing bacteria, the dominant leaders in government as well as the upper and middle classes in society made biomedicine prevail over the other types. As a result, traditional healthcare was displaced by biomedicine (Baer, 2001).

Although predominant in American healthcare and successful in treating many diseases, biomedicine cannot control every disease, and can cause side effects. Therefore, recently American people have come back to their alternative and traditional medicines, because traditional healthcare is appropriate to their own values and beliefs.

At present, many doctors recommend their patients to combine Western healthcare and alternative medicine, and consider this combination as the best way to treat disease. For instance, those who have diabetes or high blood pressure, besides taking

daily medicine, must have daily exercise and a specialized diet. Tai Chi, a traditional Chinese therapy, is good for the elderly. Many health providers advise Americans to practice Tai Chi. In Springfield, many health centers have Tai chi training classes for those who need physical therapy.

Diet for Health Improvement

Many health providers and researchers have found out that food and vegetables are good for health treatment. To avoid the fatal diseases or stresses such as cancer, heart disease, and liver damage, American healthcare providers recommend all Americans to diet, not eat or drink too much, quit smoking, get more physical exercise, and blend into nature. Such facts testify that Western healthcare has become involved with traditional healthcare. Concerning the relationship between health and diet, Chau Binh said:

> I have diabetes. The doctor recommends me not to take sugar or rice as much as I can. These foods produce much sugar in my body.

Like Chau Binh, Linh Pham mentioned:

> The doctor recommends that I must balance my food intake. If I eat too many calories, it will cause overweight and disease, because the organs such as heart and lung must work too much.

To be healthy, the Food and Drug Administration (FDA) recommends that Americans eat daily from the Food Pyramid, which encourages people to eat more cereal, rice, and vegetables than meat or milk. A good diet is necessary for good health. On the other hand, a poor diet will cause many diseases, even cancer. Much research shows that olive oil consumption would lower the risk of breast cancer by 25%. Carrots, squash, spinach, tomatoes, and sweet potatoes enhance the immune system. The smoker who eats cabbage, broccoli, and cauliflower has a lower risk of cancer development (Murray et al., 2002).

In general, American healthcare has become more and more involved in traditional healthcare methods. Through the failure of Western medicine, which cannot treat many diseases, and causes side effects, traditional medicine is a good way to improve healthcare for Americans.

American Alternative Healthcare Practices

Today, discrimination against traditional healthcare has decreased, and more Americans use traditional healthcare. When they have contact with Vietnamese culture, many Americans come to value Vietnamese traditional healthcare. Anh Nguyen confirmed that he saw many Americans go to the Asian grocery to buy ginger, garlic, and lemon grass for health treatments:

> Last year, when I went to the Asian grocery in my community to buy some food for lunch, I met an American buying some ginger, garlic, and onion. I was surprised, and asked him why he did that. He replied that he used it for herbal exhaling.

Hoa Nguyen also saw an American use traditional healthcare. He said:

> Not only Vietnamese or Asian peoples use traditional healthcare, even the whites use it. In my office, a white man, through having contact with the Vietnamese and learning the Vietnamese health treatment, frequently uses herbal medicine .

Traditional and American healthcare do not keep a distance but are often close together. Many health therapies in Western medicine have the same methods as traditional ones, and their effectiveness is the same as that of traditional therapy. Western massage is a form of traditional health practices. According to Hoang Nien:

> Every day on TV (television), on the channel for advertisements focusing on medicine, many TV shows and advertisements encourage the audience to massage the body with oil. This is a kind of coining, but instead of scratching, they have massage to make the body warm.

Another traditional health practice applied in American healthcare is steaming massage. Many Americans have used steaming massage for improving their health. More

and more steaming pools are spreading from private to public. Chiropractic care, a kind of traditional health practice, is popular in American healthcare. Many diseases require chiropractic care such as back pain, neck pain, backaches, ear inflections, and migraines. Chiropractic therapy helps more people recover. Acupuncture is one of the most traditional healthcare practices in China. It can treat patients who wish to quit smoking, control pain without side effects, and ease headaches. It helps blood pressure regulation, asthma, and stress reduction (Bailing Li, 1994). After it was refused as medical care for a long time, many health insurance companies now accept it as an effective form of treatment and offer coverage for it. At present, Baystate Medical Center accepts acupuncture as a kind of healthcare treatment and cover 25% of the cost for the patient.

Today more Americans are using alternative or traditional healthcare. Nearly half of all American adults have used alternatives at least once in their lives. Since 2002, nearly 600 million visits a year are for alternative care. Alternative medicine is likely to be a new option for healthcare access. A study at Harvard Medical School in 1993 showed that 34% of American adults had used at least one alternative therapy in 1990. Another study stated that the number of those who received unconventional care had increased 25% between 1990 and 1997 (Cowley, 2002). In 1993, there were at least two million acupuncture visits per year and Americans were spending half a billion dollars on acupuncture treatment (Bailing Li, 1994).

Alternative therapy is not only for adults, but also for children. In a recent study, 21% of American parents said that they used alternative therapy to treat their children. 73% of children who have cancer use alternative medicine (Noonan, 2002).

Today, traditional medicine is sold in the American market. All kinds of traditional medicines are available in nearly all drug and grocery stores, such as CVS, Walgreen, and Wal-Mart. Foreign herbal medicines of different sorts are all welcome in America; even many Chinese and Vietnamese medicines such as Mac Phu oil and Tiger oil for traditional healthcare practices are available for sale in the CVS in the Forest Park section of Springfield.

Alternative healthcare has developed steadily. In response to increasing traditional healthcare needs, in 1988, the National Institute of Health opened the National Center for Complementary and Alternative Medicine. Its budget also increased from $2 million to $100 million a year.

The United States of America is a country of many ethnic groups. It is not likely that the minority will always learn from and adjust to the majority culture. Everybody must learn from each other. Being aware of this problem, many educational institutions open health classes on traditional medicine for students. Columbia, Duke, and Harvard University, and the University of California, San Francisco, have Centers for Alternative Medicine (Cowley, 2002).

Through the benefits of natural therapy, more Americans are getting involved in using natural therapies. Many studies begin to research natural medicines. Many American doctors go to China or Hong Kong to study Chinese traditional medicine. Since 1987 at least 20,000 Americans have studied traditional medicine in China (Underwood, 2002).

Although different in management, strategies, and healing activities, American healthcare has been closer to traditional healthcare. American and traditional healthcare are not contrary but have mutual supports to provide healthcare for all Americans.

The Role of Health Education in Access to Healthcare

Cultural competence, cultural diversity, and multiculturalism have become more important than ever in American daily life. Since ethnic groups are growing unceasingly in America, cultural competence dominates every aspect of American life, from economics to education, and healthcare. In the United States it is evident that refugees and immigrants, instead of melting into the pot as other European groups did in the 19th century, have inclined to retain their cultural heritages.

Cultural identity is a challenge for the healthcare provider. The healthcare provider has difficulties when working with patients who are different from his own culture. As do other ethnic groups, Vietnamese adults and elderly have many problems when accessing American healthcare, because their culture is so different from that of the healthcare provider. American health providers also have the same problems when delivering healthcare services to the Vietnamese people. The problems must be cleared up for both the Vietnamese and the American healthcare provider if the goal is effective healthcare. So education has an important role for both the patient and the healthcare provider in the American healthcare system.

Health education has a great influence for Vietnamese when they are accessing the American healthcare system. Indeed, through a lack of health education, Vietnamese do not understand and therefore do not get many benefits from this healthcare system.

For instance, Vietnamese women have developed cervical cancer at a high rate compared with American women because their cancer was discovered too late. In 1987, in a study in San Francisco, 27% of Vietnamese did not know cigarettes smoking causes cancer, 28% believed that cancer is contagious, and 48% had never heard of Hepatitis B (Christopher et al., 1990).

Through a shortage of health and cultural education, health providers do not well understand the traditional healthcare of ethnic groups. Thus, they do not place enough value on traditional healthcare, and cause many problems for the patients. As a result of misunderstanding, Bien Tran gave an evidence to testify the doctor does not understand Vietnamese culture:

> Some years ago, in my Springfield Vietnamese community, a gentleman who worked for the United States Catholic Conference (USCC) was in serious health condition. His family used cutting and coining to treat his illness, causing many bruises on his back, but he did not recover. Finally, his family brought him to the hospital. In the emergency room, the doctor, not knowing the reason for the bruises, required the household members to explain the bruises before treatment. Because they were scared of what they had done, the household did not dare to tell the truth. The result is that he died.

Working with the community, many Vietnamese health workers have to explain traditional practices to American nurses because of cultural misunderstanding. Many times, the nurses in the public schools call Vietnamese health workers to complain and asked if the parents of the students had abused their children because there were many bruises on their backs. The nurse would call the police to investigate if health workers could not explain.

Because they were afraid that the healthcare provider would not understand traditional healthcare methods, Vietnamese parents have negative attitudes toward healthcare providers when trying to use traditional healthcare practices for their children.

Many parents of students only dared to coin their children on their backs (which are covered with their clothes), not on their necks, because they were afraid the school nurses would accuse them of abusing their children to the police. Thus education has an important role in healthcare access for Vietnamese and American healthcare providers. Education will help American providers and Vietnamese patients have mutual understanding, communication, and positive outcomes.

Health Education for Vietnamese

Health education needs to be delivered to Vietnamese to have effective healthcare. It is likely that Vietnamese adults and elderly in Greater Springfield have not yet received much health or cultural education since arriving in America. In America, education is a basic right for everyone. Health education is popular for all Americans. Health education is delivered in many different ways, from workshops and seminars to classes in schools, for every American and at every different level. Health education is also available on TV, radio, the Internet, and through doctor's recommendations.

As new arrivals, Vietnamese have to resolve many urgent needs, which any new arrivals must overcome, such as securing shelter and food. Because health education is likely not to be an urgent need to be resolved immediately, many Vietnamese tend to delay, then neglect it completely. Except for the young generation who are born or grown up and educated in the USA, most adults have no opportunity to take the courses and classes, or participate in workshops for healthcare. All health programs for American are abundant, but all are only for those who speak English.

Although the VACA has a monthly health-meeting day called " Health Resource Day", it is only for the elderly and focuses on updating information and some healthcare services such as diabetes and high blood pressure check-ups, rather than education.

Lack of healthcare educational materials also contributes to the reduced involvement of Vietnamese adults and elderly in American healthcare. Except for some materials written in Vietnamese by the VACA, nearly all other places, such as Baystate Medical Center, Mercy Medical Center, and other doctors' offices have no health materials written in the Vietnamese language. Through living in the community, Vietnamese adults and elderly can learn American culture and healthcare by contact with outsiders, but, unfortunately, many Vietnamese adults only have relationships with other Americans when necessary. In any problems dealing with outsiders, the VACA works for them. Therefore their knowledge is limited. Many adults and elderly feel hesitant when having contact with outsiders. Vietnamese of Greater Springfield must overcome many difficulties in order to adjust to the American healthcare system.

One of the biggest barriers to learning American culture is the English language barrier. English - speaking is a key to learning American culture and American healthcare, but most Vietnamese adults and elderly cannot speak English fluently. The Lutheran Services Agency and the USCC, which sponsor the new arrivals, only have English as Second Language (ESL) classes for the new arrivals to teach some basic English, to get a job, but not enough to successfully access healthcare. ESL classes for Vietnamese adult and elderly in the community are necessary to improve their healthcare access. In response to this need, Hoang Nien stated the following reasons for Vietnamese to learn English as their second language:

> Vietnamese need to learn much more English so that, when visiting the doctor, they can have good communication with him. It is boring when in response to any doctor's questions, they only nod their head, because they do not understand what the doctor said.

Many Vietnamese adults and elderly are not able to learn English because they cannot concentrate their mind and remember what they learn. The only way is to practice English by contact with American daily life. They learn by shopping, by seeing, watching, and listening to what happens around them. Thus it is necessary to improve English language to have adequate health programs for these people. Chau Binh confessed to not learning English in ESL classes, but in contact with daily activity:

> I am 65 years old. I do not remember what I learn. So I cannot speak English. The only way to learn English is to go shopping, to have contact with the Americans.

Culturally appropriate health education is necessary for Vietnamese in the Greater Springfield area. Many health programs, workshops, or training sessions for adults need to be offered in the community. Non-formal health education needs to develop for Vietnamese adults. During any cultural events in the community, health education information (booklets or flyers) should be delivered to all attendees; it would also be useful to have radio talk shows, videos, and health fairs.

Education will help Vietnamese change their behavior through easier adjustment to American life. Many Vietnamese adults and elderly in Greater Springfield, especially the Amerasians and their families, had no opportunity to learn American culture in Vietnam. Therefore, in America, their behavior sometimes makes many Americans and healthcare providers uncomfortable. As to being aware of the importance of health education for Vietnamese adults and elderly, Ngoc Dung explained:

> Many Vietnamese, especially Amerasians, whenever going to the doctor, always put their bare feet on the chairs in the waiting rooms. In Vietnam, such a gesture is normal, but it is impolite in the United States.

Xuan Vo expressed the same ideas as Ngoc Dung:

> When going to the doctor, Vietnamese, especially the old, often talk to the doctor in order to express their illness in miscellaneous ways from the past and present. They are afraid that if not expressed in this way (which may seem unnecessary for their doctor's understanding) the doctor will not understand their illness and will misdiagnose.

Through education, Vietnamese will recognize the necessity of regular examinations, health prevention, and the importance of compliance with their prescribed regimen, as well as of updating their healthcare knowledge. If enjoying good cultural and health education, Vietnamese will have good communication with their healthcare providers. Vietnamese will love American society and healthcare much more. Through education, Vietnamese will not be astonished at the healthcare provider's behavior, which is so different from their own. This is a way to communicate with healthcare providers and the American healthcare system.

Education for American Health Providers.

When working with the Vietnamese, American health providers must know Vietnamese culture in order to have effective healthcare relationships. Treatment is an art and a science. The Vietnamese consider the doctor as a good mother (*Thay thuoc la Me hien*). To be successful in providing healthcare for Vietnamese, the healthcare provider must become culturally competent; this means the healthcare provider must accept the different values, concepts and attitudes of the patients. The doctor will not denigrate Vietnamese traditional health medicine and consider it unreal, or fabulous. Cultural competence will make the provider appreciate the client's culture; by understanding the culture of the patient, the health provider will provide more appropriate interventions.

If the traditional health medicines or health practices are good for the patient's health, the doctor must encourage them to continue. Anh Nguyen gave an example about the health provider who is culturally sensitive. He said:

> My primary doctor is very sensitive. When seeing bruises on my back from coining, he asked me if I did it, and I said, "Yes." Then he asked me if I took medicines. I said that I took Tylenol. "That is OK," he replied, "You do not need to take more medicines".

If some traditional medicines cause danger to the patient, the healthcare provider must discourage them through education, or by asking the community leaders to intercede. For example, in traditional healthcare, coining or cupping is good for health improvement, but scratching the skin too much can cause bleeding and infection.

There are many ways to learn Vietnamese culture. The American healthcare provider can learn Vietnamese culture simply by having contact with Vietnamese patients. During a physical examination, for example, the doctor can ask what is the best way to have good communication and relationship in Vietnamese culture. The American doctor can also participate in workshops relating to multicultural issues, especially Vietnamese culture. In the workshops, American healthcare providers who work with Vietnamese patients would share experiences with their colleagues. Sometimes, in the clinic or hospital workshops, they could invite some Vietnamese speakers to present Vietnamese culture and teach cultural cues for the American providers.

In healthcare access for Vietnamese people in Greater Springfield, some health providers have cultural competence, but not all. Understanding the importance of cultural sensitiveness, one black doctor at the Southwest Community Health Center (Forest Park branch) uses Vietnamese style to work with Vietnamese patients. Many Vietnamese like this doctor and choose her as their primary doctor. One of her clients is Chau Binh. Chau

Binh is very happy because she has a primary doctor who understands Vietnamese culture. She said:

> The first time I met her, I was very surprised and wondering why she greeted me in Vietnamese language (*chao ba*). Since then, I have been in sympathy with her. Our mutual understanding and communication have increased. I am very happy to have a good primary doctor.

When working with Vietnamese, healthcare providers must have good communication skills. The American health providers have to use styles and patterns that are understandable to Vietnamese culture. This does not require healthcare providers to learn Vietnamese or other languages, but at least some basic phrases such as greetings, and other social connections, which are necessary for good communication.

All Vietnamese have a name consisting of a family name, middle name, and the first name. If you call someone, you must add Mr. for men and Mrs. or Miss (younger) for women before the first name. For instance, Mr. Thu, Mrs. Hoa, Miss Huong. When talking with the Vietnamese patient, the health provider cannot raise but should lower their voice, because Vietnamese only speak in moderate and low voices. In conversation, Vietnamese adults and elderly often respond to the doctor's questions by the word "yes" whether they agree or not. The healthcare provider must be careful regarding the meaning of word "yes." In Vietnamese language, the word "yes" may mean agreement, but it also expresses a desire to please the healthcare provider (Hoang & Eriksson, 1986).

The phrase, "thank you," is confusing to American healthcare providers. In the Vietnamese language, "*Cam on*", which means "thank you," also has the meaning of not accepting what is offered. For instance, if someone goes to see a Vietnamese family at noon, he is often invited to eat lunch with them. If he says "Thank you," it means agreement to him, but the Vietnamese will understand that he is refusing to eat.

Vietnamese in Greater Springfield, who have sympathy with their doctor, often give a gift as "thank you" for their doctor. Ngoc Dung gave some examples:

> To compensate the doctor's treatment, beside the cost paid by health insurance, many Vietnamese give their doctor a gift. This gift may be a food that they think their doctor likes most such as egg roll. The gift may also be a traditional picture bought in Vietnam when they went back for vacation.
>
> .

When greeting, Vietnamese adults and elderly like to bow their heads instead of handshaking as Americans do. Unlike other ethnic groups, Vietnamese use less touch in communication. Vietnamese or Asian culture does not permit any Vietnamese to kiss or hug in public, especially between woman and man. In communication, only the male shakes hands. Man and woman cannot walk in the street arm-in-arm. A Vietnamese woman is likely to be shy when contacting and having conversation with others, especially people of the opposite sex, and like to have physical examinations only with female healthcare providers. If they do not have trust and confidence in the healthcare provider, Vietnamese women do not dare to talk about sexual problems or birth control with him.

Vietnamese highly esteem family values. The father or elder is head of the family and has the right to make the decisions in the family. The healthcare provider must have respect for and contact with the head of the household who will make decisions for the patient.

During illness, patients often eat "*Chao*," a kind of soup composed of rice and sugar or salt. They do not eat fresh fruits or vegetables or cold water. Ngoc Dung has many experiences when working with Vietnamese women. She said:

> As the coordinator of the Vietnamese Health Project, I know that many pregnant women after delivering never drink cold water or use ice. They also do not have a shower although the American doctor recommends that they bathe.

When allergic, Vietnamese do not like to eat beef because it can cause itching or a rash. Many Vietnamese do not eat chicken, fearing "*Phong*" (Wind). During pregnancy, women find it better to avoid eating cold foods because they can cause asthma and convulsions. During the first trimester, the pregnant woman must eat hot foods such as ripe mangoes, grapes, and ginger to balance "Hot and Cold" because she is in a weak condition, and steamed rice and pork to provide food for the fetus (Purnell & Paulanka, 1998). After delivery, many Vietnamese women like to eat only rice with dried fish sauce because if they eat anything else it can cause harm to their health. They also like to sleep on a bed warmed with hot coals. Ngoc Dung continued:

> Many American providers are confused when Vietnamese women, after delivery, like to put cotton on either cochlea because they scared the noise outside causes damage to their tympanic membrane.

In short, when using the American healthcare system, both the Vietnamese and the healthcare provider need to understand their cultures to have good communication. To have good healthcare access in America, the patient and the healthcare provider must acculturate and have a mutual understanding of their respective cultures.

Education for Community Health Workers and Health Educators

Community health workers have an important role in communication between health providers and their Vietnamese clients. With their bicultural and bilingual background, they are a bridge connecting the mutual understanding between American health providers and Vietnamese clients. Besides the responsibility of providing health services such as interpreting, translating, home visits, they have to educate Vietnamese client about the American culture. Whenever contact is made with the Vietnamese, community outreach workers must explain to them the differences between American and Vietnamese cultures and how to adjust it. At the same time, the community outreach

workers must encourage the Vietnamese client to become more involved in American healthcare. On the other hand, they must help health providers recognize and understand the cultural differences when they are in contact with the Vietnamese needing health services. This is an effective way to resolve the cultural problems between health provider and the client. Community health workers are really the people who can resolve cultural differences whenever the conflict occurs.

Education for the Policy Makers

The policy maker plays an important role in healthcare access for immigrants and refugees. Depending on appropriate health policy, people will become involved in more or less, and their health conditions will improve or not. To avoid the problems for immigrant people in healthcare services as today in which the policy makers only respond to crises rather than reasoned plans, the policy makers must become familiar with the cultural backgrounds of the immigrants they serve. Thus, they must be educated in cultural settings. If the policy makers have the multicultural knowledge, it is certain they can develop policies, which respond to the culture of the immigrants, and their health needs.

In brief, health education is very important for healthcare access for Vietnamese adults and elderly in Greater Springfield. By providing health education for the Vietnamese, American health providers, community health workers, as well as policy makers, healthcare access will improve unceasingly.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Culture has an important role in being human; it influences the process of human growth and development. Culture can change an individual's behavior when in contact with a new cultural environment, but the essence of each individual's culture remains for the rest of his life.

To prosper in this country, the new arrival must acculturate to the host country, but the level of acculturation is different based on the characteristics of each ethnic group. As an ethnic group, Vietnamese refugees and immigrants in America must adjust to the American healthcare to survive and advance, but the acculturation of Vietnamese is very different from that of other ethnic groups.

In general, Vietnamese do not assimilate entirely to the host culture. This is because Vietnamese people try to keep their own culture as much as possible. Geographically, Vietnam is a transportation center between China, Japan, Korea and Europe, and a convenient place for business establishments and military bases in Southeast Asia. Therefore, Vietnam has a very important role in Southeast Asia, and whoever controls Vietnam can control the Southeast Asian region. In the past, China occupied Vietnam for more than 1,000 years, from the first century B C to the 9th century AD. During the invasion, the Chinese wanted to assimilate Vietnamese people and convert them to Chinese culture but could not. Later on, in the 19th century, France

invaded Vietnam and colonized the country for nearly 100 years (1890-1945) but the Vietnamese still have their own culture.

Although under the Chinese and French domination, the Vietnamese still had their own healthcare system. Beside Chinese and western medicine, Vietnamese have their own medicine.

When Vietnamese refugees and immigrants came to America in 1975, the U.S government wanted to assimilate them into the American society by dispersing them (first wave, and then the latter, second and third waves) over nearly all 50 states, but the policy failed. No sooner did they arrive, but most Vietnamese concentrated in three states: California, Texas, and Louisiana, where they tried to live in their own communities. Even in Boston and Worcester, and in other major cities, Vietnamese have always been inclined to concentrate within their own communities.

Like other Vietnamese in America, the Vietnamese of the Greater Springfield do not assimilate entirely to American culture and healthcare. Although resettled in America for a long time. Vietnamese language is still kept in the family. The family is still an extended family unit where the parents, children, and grandchildren live together in the same house. Hardly any Vietnamese elderly live in nursing homes, and no single children over 18 years old live separately from their parents. Many Vietnamese buy two or three floored family houses to share with their married children. Vietnamese food is always served in the family. Regarding religion, the Vietnamese like to go to Vietnamese church better than American church. The Buddhist Center was established for Vietnamese Buddhists of Springfield. In matters of the family, the father is the head of the family and makes many decisions for the whole family. Children continue to obey their parents. The

wife is considered subordinate to the husband. Many cases of sexual abuse or domestic violence are still kept from leaking to the outside because Vietnamese culture esteems family values so highly. Every problem must be resolved within the family or among relatives before seeking help publicly. The divorce rate is low. In entertainment, Vietnamese movies and music are preferred, and Chinese films translated to Vietnamese are welcomed.

In the larger community, traditions are still preserved. Like in Vietnam, Vietnamese of Greater Springfield like to live together in a community to support each other. In the community, every Vietnamese speaks the native language. Annually, the Vietnamese New Year is celebrated respectfully. All traditional customs are strengthened, presents are given to the eldest, and awards are given to students who excel in school. Traditions include ancestor's memory celebrations, the reading of scrolls to educate the younger generation on preserving the culture, and traditional dances and music. In traditional festivals or ceremonies, Vietnamese women wear the Vietnamese "ao dai", a traditional dress that originated thousands of years ago. In the fall, there is the Vietnamese Mid-Autumn ceremony for children, with a lantern procession, traditional cake, and dragon dance. Weddings and funerals are all celebrated according to Vietnamese culture. Although the Vietnamese population is only 5,000 people in Springfield and 2,000 in other towns of Western Massachusetts, there are four Vietnamese food markets in Springfield, which supply food and accessories for this population.

Every year, many Vietnamese go back to Vietnam to celebrate Vietnamese New Year. Nearly all Vietnamese in Springfield go back to Vietnam at least once in their life

to see their relatives. Even the young like to visit Vietnam, despite being born in America. Living in America, Vietnamese still have their own traditional healthcare. Traditional healthcare in the Greater Springfield area not only exists but is also growing. Although many Vietnamese have lived in America for a long time (more than 10 years), have a high level of education and graduated from American colleges, they still do not reject their traditional healthcare. Others who are integrated into American culture, who have the bicultural and bilingual background, and who work for American healthcare, also do not refuse traditional healthcare. Instead, many traditional practices are strengthened. They grow many herbal medicines in their gardens, and many plants and herbal medicines are also sold in grocery markets. Even many traditional medicines such as Mac Phu, imported from Singapore, are sent back to their relatives in Vietnam. The high rate of traditional healthcare usage (92.8%) in this Vietnamese community proves that the Vietnamese highly value their culture.

Yet Vietnamese do not keep apart from American culture, as do the Chinese, who typically concentrate within their own communities. Vietnamese know how and when to adjust to American culture. They encourage their children to go to school. They urge their children to become good students with a high GPA, and reward them if they are successful. At school, their children eat American food and speak English. In the workplace, they work hard, diligently, and intelligently. They get involved in many activities in Springfield, such as visiting nursing homes and serving food at the homeless shelters. Many awards are given to them.

In healthcare, almost all Vietnamese have a primary doctor. Most Vietnamese of Greater Springfield have primary doctors and health insurance coverage. They participate

in American healthcare, keeping appointments with their doctors on time. Nearly all respondents answered that they have visited their doctors on time and appreciate the American healthcare system. All respondents welcome American healthcare.

Many Vietnamese adults in Springfield, although busy with their daily activities, try to learn the American culture to better adjust to American healthcare. Many Vietnamese go to college to complete the education that was unfinished in Vietnam. Many graduate from American colleges and contribute a great deal to American society. This fact testifies that Vietnamese also always want to adjust their life to American society.

The interesting feature of the Vietnamese people's acculturation is that they know to choose what is good for their life, and eliminate whatever makes their life uncomfortable. More important Vietnamese know to take what is appropriate to their culture from different cultures and combine them together to make it their own. For instance, in history, Vietnamese blended three doctrines of Buddhism, Confucianism and Taoism into "three teachings" to conduct lives. Although Vietnamese traditional healthcare is different from Chinese and Western healthcare, Vietnamese know to take what is good and appropriate to their environment. For instance, in healthcare history, Tue Tinh, the first health scholar, applied Chinese medicine for the Vietnamese based on the local herbal plants in Vietnam. He knew to eliminate ginger and cinnamon. Using too much ginger and cinnamon cannot be appropriate to the Vietnamese because Vietnam climate is warmer than China. In traditional healthcare treatments, the Vietnamese know when to use Chinese medicine. If they have a cough, fever, or vomiting, they will use

herbal medicine grown in their garden or sold in the grocery markets. Otherwise, they use Chinese medicine.

Vietnamese of Greater Springfield also know when to use Western medicine. In general, they use traditional healthcare practices to treat general illness such as fever and headaches. If their treatment is not effective, they will then go to the doctor. They know that only Western healthcare can treat diseases that are caused by bacteria or viruses.

In Vietnamese families, parents always encourage their children go to school; but at home, they teach the Vietnamese language. They like to let their children participate in the Vietnamese youth groups. Children eat American food in school but eat Vietnamese food at home. In daily life, they wear American clothing in the workplaces but wear traditional outfits at weddings, and funerals are celebrated with Vietnamese customs.

If people visit the Vietnamese community in Greater Springfield, they cannot distinguish which houses or buildings belong to Vietnamese and which belong to Americans, but if they go inside, they will see the difference. All cultural traits are displayed in the furniture and decorations, such as sofas, pictures, scrolls, and plaques in Vietnamese styles.

As other Asians, Vietnamese like the present time better than future. They value present time and neglect future time. In Vietnam, Vietnamese tend to not care about doctor's visit on time. Therefore they often come late. But Vietnamese of Greater Springfield go to the doctor on time. Most respondents answered that if they have an appointment with the doctor, they will come on time. However, to their community, they like to come late. In a wedding or any party, Vietnamese always come late because Vietnamese culture is more present-oriented.

Another unique feature of Vietnamese using American healthcare is that, according to the theory of acculturation, the more individuals participate in the host healthcare the less they participate in their traditional healthcare. But in reality, many Vietnamese participate in the American healthcare while continuing to use traditional healthcare. In theory, the more educated they are, the less likely they are to get involved in traditional culture; and that acculturation depends on time, meaning that the longer they live in the host country, the less likely they are to use traditional culture. But this study shows that the use of traditional healthcare does not depend much on time living in America, level of education, or income. Vietnamese in Springfield are involved in traditional healthcare even though they have high education levels.

Through the characteristics of Vietnamese acculturation in America, it is evident that Vietnamese in Greater Springfield have not separated from or rejected American healthcare. Instead they are actively involved in it, they have the opportunity to use Vietnamese healthcare or American healthcare if necessary. Whatever is complicated and unreal in perception or access in traditional healthcare, they are ready to reject. Whatever is necessary to improve healthcare access such as coining, cupping, and herbal exhaling, is kept and strengthened. Moreover, at present, American healthcare itself is more and more inclined to have alternative medicine. Vietnamese are flexible in the use of traditional medicine and healthcare access. For instance, if animal and tropical herbal medicine that cannot grow or be bought in America, Vietnamese are willing to replace them with western medicine instead.

In short, Vietnamese acculturation is different from the acculturation of other ethnic groups. Vietnamese do not entirely assimilate to the American healthcare as

quickly as Japanese, or keep isolated in enclaves as the Chinese do (Ruthledge, 1992). On the contrary, Vietnamese select what is good for their health condition, keep whatever of their own that is good for their healthcare, and are willing to refuse whatever impedes their involvement in the American healthcare system.

Recommendations

The United States of America has an increasing number of refugees and immigrants from third world countries, and is becoming more and more of a multicultural country. White immigrants from Europe who were absolutely privileged to immigrate to America in the 19th century are becoming more and more a minority group in American society both because the waves of European immigrants have decreased and because the white birth rate has slowed down in recent decades. It is clear that from the 16th to the 20th century, any immigrant resettled in America sooner or later would be assimilated into the American culture. Today, it is different. The newer arrivals, from ethnic backgrounds, are more inclined to keep their own culture, and have found it hard adjusting to the mainstream.

Although the number of refugees and immigrants has increased, the government has no policy for them. The policy at present is only temporary, to resolve existing problems. There is no policy for the future. It is time to reconsider the healthcare of all Americans. The government must pay more attention to the other cultures. They must develop policies for these minorities. One of the basic needs is to value their culture more highly.

Besides health education for new arrivals to understand and actively participate in the American healthcare system, and for healthcare providers, to obliterate the prejudices against their patients, American healthcare needs more research about traditional medicines and healthcare practices, not only of the Vietnamese but also of other ethnic groups in America. Every healthcare system has advantages and disadvantages. So far, traditional ethnic healthcare has been neglected in America because of the lack of research, and American government's concern. If traditional healthcare is more esteemed, it is certain that the American healthcare system will have increased benefits for everyone, including the Vietnamese.

Everyone must be concerned about the upcoming generation who was born and/or raised in America. The parents, educators, and policy makers must help them have cultural sensitivity in their families and in society. Although being Americanized, they still have to keep rooted in their ethnic culture. If they have cultural sensitivity, the relationship between family, society and themselves will not be broken down, and American healthcare will advance unceasingly because American healthcare accepts the differences in its healthcare access.

APPENDIX A

INTERVIEW QUESTIONAIRE

I. What is the respective level of the involvement of Vietnamese adults and elderly in Greater Springfield with the American healthcare system and their traditional health practices?

1 What do you think (good or bad) about the American healthcare system? Why do you think so?

2 Do you go to your primary doctor frequently? Do you have regular check up? If yes, how do you feel? If no, why do you not go? In Vietnam, did you go to the doctor? How did you feel?

3 Have you been involved in prevention care? Do you regularly have a mammogram, Pap smear, or prostrate cancer test? If yes, how often? How do you feel? If no, why do you not go? Could you let me know prevention in Vietnam?

4 Do you access traditional health care? If yes, when do you use it? How do you feel? If not, why? In Vietnam, did you use traditional health care? How did you feel?

5 Do you have a health problem(s)? How do you deal with it? Do you go to an American doctor or traditional health practitioner? How do you feel about the treatment of the doctor or traditional health practitioner?

6 If you have symptoms such as fever, headache, and coughing, how would you deal with? Do you seek help from family members and or friends? Do you perform self-care and self-treatment? If yes, why do you prefer self-care and self-treatment?

7 If you were sick, would you go to the doctor or use traditional healthcare practices such as coining or cupping? If yes, why? When have you used American healthcare, when traditional healthcare? How do you feel about using both? Which is better?

8 Between American and traditional healthcare, what is your favorite? Why?

II. What access problems have the Vietnamese adults and elderly encountered?

1 How old are you?

2 How long have you been in the United States?

3 Do you speak English? When going to the doctor, do you need an interpreter? How do you feel when going to the doctor without an interpreter?

1. What is the highest level of education you have completed?

2. Since arriving in the United States, have you attended any school, job training, ESL classes, or college?

3. Do you eat Vietnamese food daily? If yes, why? Do you like American food? Why? How often do you eat American food? Which kind of food do you think is good for you: American or Vietnamese? Why?

7. Are you involved in the Vietnamese community (i.e. attending Vietnamese New Year celebration)? How often do you go to church/temple? Why? How do you feel?

8. Are you employed? What job(s)? Does your job(s) cover health insurance? How do you feel about your insurance? Is your insurance necessary for you?

9. How much income did you and your family earn in 2001?

10. Do you have insurance (Medicare and Medicaid)? Are you satisfied with your health insurance? In what ways does your insurance improve your health?

11. If you practice traditional health practices, in what ways do traditional care practices benefit or harm you?

12. Do you adhere to your treatment, especially with preventive therapy? If yes, why? If not, why? How do you feel about adhering to your treatment?

13. In what ways does American healthcare benefit your health?

III. How could the American healthcare system be better integrated into Vietnamese Traditional Healthcare?

1 Do you think that Western healthcare can change to better for you? Why do you think so?

2 In what ways can American healthcare change to be of good quality?

3 What is the best way (i.e. Medicine, access, therapy) to help you? If Western health does not change, how would it affect you?

4 Do you think that there is a conflict between traditional healthcare and Western healthcare? If yes, why? The consequences of that conflict?

5 Do you think that traditional healthcare can cooperate with the Western healthcare? In what ways can the two cooperate?

6 Would you have any problem(s) if American doctor does not to regard Vietnamese culture?

7 Would you have any benefits if American providers provide culturally sensitive healthcare when working with Vietnamese people?

IV. How does health education have an important role in healthcare access for Vietnamese adults and elderly and American health providers in the Greater Springfield area?

1 Do American providers need to be educated in Vietnamese culture?

2 Do American providers have benefits if they learn Vietnamese culture and have sensitive healthcare with the Vietnamese adults and elderly? Why?

3 In what ways does American provider learn about Vietnamese culture?

4 Do Vietnamese adults and elderly need to be educated in the American culture? If yes, why?

5 What benefits do Vietnamese adults and elderly get when they learn American culture?

6 In what ways do Vietnamese adults and elderly learn the American healthcare system?

7 In healthcare access, if both American providers and Vietnamese clients are educated in health culture, which benefits do they get? If not, which consequences affect their healthcare? Why?

CÂU HỎI PHỎNG VẤN (in Vietnamese)

I. Mức dộ tham gia vão hệ thống Y tế của Mỹ cung như Y tế Cổ truyền của người Việt Nam trưởng thành vã lớn tuổi ở Springfield vã phụ cận?

1. Ông (bà) nghĩ gì (tốt hay xấu)về Hệ thống Y tế ở Mỹ? Tại sao ông (bà) lại nghĩ như thế?

2. Ông (bà) có hay di khám bác sỹ gia dình không? Ông (bà) có hay di khám tổng quát không? Nếu có, ông (bà) cảm thấy như thế não? Nếu không, tại sao ông (bà) không di? Khi còn ở Việt Nam, ông (bà) có hay di bác sỹ không? Ông (bà) cảm thấy thế não?

3. Ông (bà) có tham gia vão sản soc sức khoẻ phòng ngừa không? Ông (bà) có hay di khám ngực, khám tử cung, hay khám niệu dao không? Nếu có, bao lâu thì di khám một lần? Khi di khám như vậy, ông(bà) cảm thấy thế não? Nếu không , tại sao lại không di khám? Ông (bà) cho biết ở Việt Nam Y tế phòng ngừa như thế não?

4. Ông (bà) có dùng Y tế Cổ truyền không? Nếu có, khi não ông (bà) dùng? Ông (bà) cảm thấy như thế não khi dùng Y tế Cổ truyền? Nếu không, tại sao? Khi còn ở Việt Nam, ông (bà) có hay dùng Y tế Cổ truyền không? Ông (bà) cảm thấy như thế não?

5. Ông (bà) có bệnh tật gì không? Nếu có, ông (bà) dối phó với no bằng cách não? Dể chửa bệnh, ông (bà) có di bác sỹ hay thấy thuốc Dông y? Ông (bà) cảm thấy như thế não khi di chửa bệnh với bac sỹ? với thấy thuốc Dông y?

6. Nếu thấy triệu chứng như sốt, nhức dầu, ho....Ông (bà) giải quyết bằng cách não? Ông (bà) có cần sự giúp dỡ, khuyến bảo của gia dình, bạn bè.. Ông (bà) có tự chửa lấy không? Nếu có, tại sao ông (bà) lâm như vậy?

7. Khi ông (bà) bi bệnh, ông (bà) có di bác sỹ hay dùng Y tế Cổ truyền như cạo gio, giác hởi? Khi não ông (bà) dùng Y tế Tấy phương, khi não dùng Y te Cổ truyền? Nếu dùng cả hai, ông(bà) cảm thấy như thế não? Y tế nào tốt hơn?

8. Giữa hai phương pháp chăm lo sức khoẻ Y tế Tấy phương vã Cổ truyền, ông (bà) thích Y tế não hơn? Tại sao?

II. Những khó khăn, trở ngại khi di khám bác sỹ của người Việt-Nam trưởng thành và lớn tuổi ở Springfield và phụ cận?

1. Năm nay ông (bà) bao nhiêu tuổi?

2. Ông (bà) sống ở nước Mỹ được bao nhiêu lâu?

3. Ông (bà) có nói được tiếng Mỹ không?Khi di khám bệnh , ông (bà) có cần thông dịch viên không? Ông (bà) cảm thấy như thế nào khi di khám bệnh không có thông dịch viên?

4. Trình độ học vấn của ông (bà) tới đâu rồi?

5. Từ khi sang Mỹ tới bây giờ, ông bà có di học không? (tiếng Anh, huấn luyện nghề nghiệp, đại học).

6. Ông (bà) có ăn đồ Việt Nam hàng ngày không? Nếu có, tại sao? Ông (bà) có ăn đồ ăn Mỹ không? Nếu có, tại sao? Bao lâu thì ông (bà) ăn đồ ăn Mỹ? Giữa hai loại đồ ăn Mỹ và Việt Nam, đồ ăn nào bổ dưỡng cho sức khoẻ của ông (bà)? Tại sao?

7. Ông(bà) có tham gia vào sinh hoạt cộng đồng không? (chẳng hạn như tham dự tết cổ truyền hàng năm) Ông (bà) có hay đi nhà thờ, chùa không? Nếu có, tại sao? Nếu không, tại sao? Ông (bà) cảm thấy như thế nào?

8. Ông (bà) có đi làm không? Nếu có, công việc tên là gì? Công việc làm của ông (bà) có bao bảo hiểm Y tế không? Ông (bà) có cảm nghĩ gì về bảo hiểm Y tế? Bảo hiểm Y tế cần thiết cho sức khỏe của ông (bà) không?

9. Ông (bà) có thể cho biết lợi tức năm 2001 vừa qua của gia đình ông (bà)?

10. Ông (bà) có bảo hiểm Y te không (thẻ Medicaid, Medicare)?Ông (bà) có thỏa mãn về Y tế không? Cách nào thì Y tế tăng tiến sức khoẻ của ông (bà)?

11. Nếu ông (bà) dùng Y tế Cổ truyền, cách nào thì Y tế Cổ truyền mang lại lợi ích cho ông(bà)?

12. Ông(bà) có tích cực vào việc chữa trị, nhất là Y tế phòng ngừa không? Nếu có,tại sao lại như vậy? Nếu không, tại sao? Ông (bà) cảm thấy như thế nào khi tích cực vào Y tế phòng ngừa?

13. Nếu ông (bà) dùng Y tế Tây phương, cách nào thì Y tế Tây phương mang lại lợi ích cho ông (bà)?

III. Làm sao để Hệ Thống Y tế của Mỹ có thể phù hợp tốt hơn với Y tế Cổ truyền Việt Nam?

1. Ông (bà) có nghĩ rằng hệ thống Y tế của Mỹ nên thay đổi cách làm việc và ứng xử để thích hợp với lối sống của ông(bà)? Nếu có, tại sao ông (bà) lại nghĩ như thế? Nếu không, tại sao?

2. Cách thức nào Y tế của Mỹ thay đổi để phục vụ ông (bà) cách tốt nhất?

3. Cách thức phục vụ nào (về thuốc men, cách chữa bệnh...) của Y tế Mỹ đem lại hiệu quả nhất cho ông bà? Nếu không thay đổi. sẽ ảnh hưởng đến ông (bà) như thế nào?

4. Ông (bà) có nghĩ rằng có sự mâu thuẫn giữa y tế của Tây phương và Y tế Cổ truyền của người Việt nam không? Nếu có, tại sao lại như vậy? Xin ông (bà) cho biết hậu quả của sự mâu thuẫn đó như thế nào?

5. Ông (bà) có nghĩ rằng Y tế Tây phương và Y tế Cổ truyền có thể phối hợp với nhau? Nếu phối hợp với nhau được, thì phối hợp cách nào?

6. Ông (bà) có nghĩ rằng sẽ có trở ngại nếu bác sỹ Mỹ không để ý gì đến văn hóa Việt Nam khi khám bệnh cho ông (bà)? Nếu có, ông (bà) nghĩ gì về bác sỹ đó, .Nếu không, tại sao?

7. Ông (ba) có nghĩ rằng sẽ rất có nhiều ích lợi cho ông (bà), nếu bác sỹ Mỹ khám bệnh cho ông (bà) biết cư xử với ông (bà) theo cách thức văn hóa Việt Nam?

IV. Tại sao giáo dục Y tế có một vai trò rất quan trọng khi tiến hành Y tế cho người Việt Nam trưởng thành và lớn tuổi và cho bác sỹ người Mỹ ở Springfield và phụ cận?

1. Ông (bà) có nghĩ rằng để khám bệnh mang lại hiệu quả hơn cho người Việt Nam, bác sỹ Mỹ nên được học hỏi về văn hóa Việt Nam?

2. Bác sỹ Mỹ sẽ được lợi ích gì nếu họ học hỏi tiếng Việt, văn hóa Việt Nam và áp dụng lối khám bệnh theo văn hóa Việt Nam? Tại sao?

3. Bác sỹ Mỹ sẽ học về văn hóa Việt Nam bằng cách thức nào? Đường lối nào?

4. Người Việt Nam trung niên và lớn tuổi có cần phải học văn hóa, lối sống của người Mỹ không? Nếu có, tại sao?

5. Nếu người Việt Nam (ông bà) học tiếng Mỹ và lối sống của người Mỹ, thì sẽ được những lợi ích gì?

6. Cách thức nào tốt nhất để người Việt nam học tiếng Mỹ và văn hóa Mỹ?

7. Nếu bác sỹ Mỹ và bệnh nhân người Việt Nam đều học văn hóa của nhau, thì có những lợi ích gì? Nếu không, sẽ có những hậu quả gì về sức khoẻ cho người bệnh nhân? Tại sao?

APPENDIX B

LETTER OF CONSENT

March 26, 2002

Dear_____

I am a doctoral candidate in the Center for International Education, University of Massachusetts. I am writing this letter to invite you to participate with me in my study of the interaction between culture and healthcare for Vietnamese refugee and immigrant adults and elderly in Greater Springfield.

The results of this study will help Massachusetts Department of Education, Massachusetts Department of Public Health in an effective educational and healthcare planning for the Vietnamese refugees and immigrants in Springfield, Massachusetts, and all over the United States.

I will interview you about one hour and half in four following questions:

- What is the respective level of involvement of Vietnamese adults and elderly in Greater Springfield with the American Healthcare System and their Traditional Healthcare practices?
- What access problems have the Vietnamese adults and elderly encountered?
- How could the American Healthcare System be better integrated into Vietnamese Traditional Healthcare?
- How does health education have an important role in accessing healthcare for Vietnamese adults and elderly people in Greater Springfield?

In the interview, you can use either Vietnamese or English if you feel easier to express your ideas and your experiences. The interview will be tape-recorded.

All your responses from the interview will remain confidential and be only used for research purposes. You can withdraw from part or all of study at any time, as well as to review material before dissemination.

I will protect your identity by giving you pseudonyms. If you have any questions, please feel free to call me at (413) 796-8394.

Thank you for your cooperation.

Duong Chu

Participant:

I have read the above contract and I agree to participate in the study

_____ _____

Interviewee's signature Date

THƯ XIN THOẢ THUẬN (in Vietnamese)

Ngày 26 tháng 3 năm 2002

Kính gởi_____

Là một ứng cử viên bằng tiến sỹ thuộc Trung Tâm Giáo dục Quốc tế, Trường Đại hoc Massachusetts, tôi xin viết thư này kính mời qui vị tham gia với chúng tôi cuộc nghiên cứu về tương quan ảnh hưởng giữa văn hóa và Y tế của người Việt Nam trung niên và lớn tuổi tại Springfield và phụ cận.

Kết quả cuộc nghiên cứu này sẽ giúp Bộ Giáo dục, Bộ Y tế Công Cộng của tiểu bang Massachusetts có một chính sách hữu hiệu hơn về Y tế và Giáo duc cho người Việt Nam tại Springfield và phụ cận, tại tiểu bang Massacusetts, cũng như cho người Việt Nam khác trên toàn nước Mỹ.

Tôi xin dược phỏng vấn qui vị trong vòng 1 giờ 30 phút về bốn câu hỏi :

- Người Việt Nam trung niên và lớn tuổi ở Springfield và phụ cận da tham gia vào Y tế của người Mỹ cũng như duy trì Y tế cổ truyền của mình ở mức độ nào?
- Những yếu tố nào cản trở người Việt Nam trung niên và lớn tuổi ở Springfield và phụ cận tham gia vào Y tế Mỹ?
- Làm sao để Hệ thống Y te của Mỹ có thể phù hợp hơn vàoY tế truyền thống của người Việt Nam?
- Tai sao giáo dục Y tế có vai trò quan trọng cho người Việt Nam trung niến và lớn tuổi và nhân viên Y tế Mỹ.

Trong khi phỏng vấn, qui vị có thể dùng tiếng Việt Nam hay tiếng Anh nếu qui vị cảm thấy tiếng nào giúp qui vị diễn tả ý tưởng và những kinh nghiệm của qui vị dễ dàng hơn. Cuộc phỏng vấn xin dược ghi vào máy ghi âm để để tiện việc tham khảo.

Tất cả những câu trả lời của qui vị trong cuộc phỏng vấn sẽ dược giữ kín và chỉ dược dùng cho cuộc nghiên cứu mà thôi. Qui vị có thể khước từ một phần hay toàn thể cuộc nghiên cứu bất cứ lúc nào; cũng như qui vị có thể duyệt xét lại tất cả những điều ghi trong cuộc phỏng vấn trước khi dược phát hành cho công chúng.

Để cho thong tin của qui vị dược giữ kín, tôi sẽ dùng tên ẩn danh của qui vị. Mọi thắc mắc, xin vui lòng diện thoại cho tôi số (413) 796-8394.

Xin chân thành cảm ơn sự hợp tác của qui vị.

Dương Chu

Tham dự viên:

Tôi đã đọc Tờ thỏa thuận và đồng ý tham gia phỏng vấn

Ký tên Ngày... tháng... năm

APPENDIX C

PARTICIPATORY OBSERVATION

Protocol

(Sample)

I. Demographic Information

Time: 8:00- 9:45 A.M. Date:
Place: The clinic.

A young Vietnamese lady had an appointment at clinic at 8:00 a.m. for examination. The notice was mailed to her a week before the scheduled day. The lady and her brother arrived at the clinic at 8: 00 A.M.

Descriptive notes

At 8:00 in the morning, the young lady and her brother (I believe he is her brother) entered to the waiting room. After a little confusion, they waited in line to enter the reception room (there are three clients before them). (1)

-Five minutes later, they stood in front of the reception room, and the brother handed the appointment notice to the receptionist. A registered ticket, numbered 6, was handed to him, and they sat quietly on a bench in the waiting room (2).

-Another client stood in line.

-At 8:15, the receptionist announced number 6.

The two young people stood up and went to the reception room again. The receptionist asked the young lady to confirm her name, address, and the person to be contacted if she was in an emergency situation. Because she did not speak English fluently, her brother hesitated to answer instead. As a result, an interpreter (the researcher) appeared to help them (3)

The brother was glad and thanked the interpreter for his help.

After signed paperwork, the young lady was weighed, and went to radiological room for lung X-ray.

-At 8:30, because there was no call from the receptionist for doctor's examination, they felt uncomfortable and expressed their anxiousness to the researcher. The researcher calmed them down.

8:45: The examination room was now vacant. The nurse told them to go in. All of the paperwork and an x-ray film were already on the nearby table.

9:00 an intern medical student entered the room, said "Hello" and introduced his name.

-While asking the young lady (through the interpreter) some questions about symptoms, the TB test, and household contacts, the intern student took notes in the files. He then took the x-ray film and all paperwork to the doctor's room (4)

9:30: the doctor came with the intern student. He said nothing; but seeing the x-ray film, and concluded that the x-ray was good. However, the skin test was positive. He recommended her nine months of preventive therapy and asked if she agreed. He did not regard the presence of her brother. The interpreter (researcher) interpreted what the doctor just said to the lady. (5) She and her brother agreed with the preventive therapy. Afterwards, both the doctor and the young lady signed the consent paper.

At 9:45 the young lady and her brother left the clinic.

II. Reflective Notes

(1)-The appointment was at 8:00 A.M. They came on time.

The Vietnamese culture is more present oriented. They value present time and neglect future time. But in America, they try to arrive on time for appointments.

(2) (3) Vietnamese highly esteem family values and hierarchy. The brother represents his sister to answer the receptionist.

(4) It is good for the intern student to say "Hello" and introduce himself to the client. By doing so, he has created a mutual communication. It would have been better if he said "Hello" in the Vietnamese language. Also, he should have talked with her brother.

(5) Similarly, the doctor should have said "Hello" in Vietnamese. More importantly, he did not consult with the brother about the decision of the nine months preventive therapy (lack of communication). In Vietnamese culture, the oldest family members have rights to make any decision for the family.

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